Rev.07.30.23

DBHDS INSTRUCTION

Subject: SOP for ensuring the Commonwealth addresses all barriers that may occur during the discharge process to ensure that an individual shall be served in the most integrated setting consistent with their informed choice and needs, upon discharge from the Training Center.

I. Purpose.

Systematic processes for ensuring individuals currently living in the Training Center and their Authorized Representatives (AR)/Substitute Decision Makers (SDM) are informed of the continuum of residential, day activity and employment choices that are available in the community and to address any barriers to their effort to transition successfully into the community.

II. Definitions.

a. **Individual:** This means a person who is receiving supports in a training center.

b. **Authorized Representative/Legal Guardian/Substitute Decision Maker (AR/LG/SDM):** This means a person permitted by law or in the Human Rights Regulations (12 VAC 35-115-30) to authorize the disclosure of information or to consent to treatment and services or participation in human research. The decision-making authority of an authorized representative/substitute decision maker recognized or designated under these regulations is limited to decisions pertaining to the designating provider. Legal guardians, attorneys-in-fact, or health care agents appointed pursuant to § 54.1-2983 of the Code of Virginia may have decision-making authority beyond such provider.

c. **Community Integration Manager (CIM)**: This means the central office position physically located at a training center that is responsible for coordinating the implementation of policies, procedures, regulations and other initiatives related to ensuring individuals residing in training centers are served in the most integrated setting appropriate to their needs and desires. This position provides support and direction to all aspects of the individual's transition to the community including addressing identified barriers to discharge.

d. **Community Services Board (CSB)**: This means the public body established pursuant to §37.2-501 or §37.2-602 of the Code of Virginia that serves the area in which an adult or in which a minor's parent or guardian resides, and that provides support coordination and discharge planning support to an individual living in a training center.

e. **Personal Support Team (PST)**: This means a team, formally known as an interdisciplinary team (IDT), of professionals, paraprofessionals, and non-professionals who possess the knowledge, skills, and expertise necessary to accurately identify a specific individual's comprehensive array of needs and design a program that is responsive to those needs. At a minimum, the PST includes the individual, AR/SDM, CSB support coordinator, and other invited members of the individual's interdisciplinary team or those involved in the individual's life.

f. **Barrier**: Any circumstance that hinders an individual's ability to live and receive supports in the most integrated setting appropriate to meet his/her needs.

g. **Regional Support Team (RST)**: This means a regional team facilitated by a DBHDS employee that is composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs.

h. **Family Resource Consultant (FRC)**: This is the central office position responsible for assisting families/authorized representatives/substitute decision makers of individuals residing in various state and community facilities with resources to aid in the community integration process.

i. **Post Move Monitor:** This means a training center or designated DBHDS employee whose job functions include monitoring and assisting individuals as they transition from the training center to community living to ensure that the ongoing needs of the individual are being met in the new placement and that essential and non-essential supports agreed upon in the discharge plan are being provided. This includes monitoring the individual's adjustment to his or her new home; recommending additional support services to the individual, AR/SDM, provider, or CSB; providing necessary recommendations to the community provider to resolve identified concerns; and documenting steps on the post-move monitoring action plan.

III. Procedures:

a. The CIM shall be engaged in addressing barriers to discharge in the following circumstances:

i. The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.
ii. The PST is having difficulty identifying or locating a particular type of community placement, services or supports for an individual within 30 days of development of a discharge plan.
iii. The PST cannot agree on a discharge plan outcome within 15 days of the annual PST meeting, or within 30 days after the admission to the Training Center.
iv. The individual or his or her Authorized Representative opposes discharge after all the requirements described in Section IV.B.9 have been satisfied or refuses to participate in the discharge planning process.
v. The individual is not discharged within three months of selecting a provider, as described in Section IV.C.2. The PST shall identify the barriers to discharge and notify both the facility director and the CIM;or
vi. The PST recommends that an individual remain in a Training Center. If the individual remains at the Training Center, an assessment by the PST and the CIM will be performed at 90-day intervals from the decision for the individual to remain at the Training Center to ensure that the individual is in the most integrated setting appropriate to his or her needs.

b. The CIM should be informed and review all circumstances that are or may become barriers. A barrier may arise from various sources. It is the CIM's responsibility to work with the Community Integration Project Team and Personal Support Team to clearly identify barriers and develop strategies to resolve them. Potential barriers may include:

i. <u>Community Services Board Support Coordinator:</u>
- ✓ Did not participate in pre move meetings.
- ✓ Did not present viable community options.
- ✓ Did not complete paperwork in a timely manner
- ✓ Did not identify and/or secure community support providers.
- ✓ Is not responsive to attempts to contact.

ii. <u>Individual:</u>
- ✓ Has not chosen a provider.
- ✓ Funding Concerns
- ✓ Medicaid ineligible
- ✓ Medical concerns
- ✓ Move requires more restrictive support.
- ✓ Not a good match with selected provider
- ✓ Resistance to participation in the process

- ✓ Unsuccessful visits

iii. Authorized Representative/Substitute Decision Maker (AR/SDM):

- ✓ Does not choose the provider after completion of visits.
- ✓ Reluctance or refusal to explore more integrated options.
- ✓ Has not completed required paper work.
- ✓ Was not able to participate in pre move or other planning meetings.

iv. Training Center

- ✓ Availability of equipment
- ✓ Disagreement with discharge date
- ✓ Failure to develop alternate treatment or support methods.
- ✓ Inaccurate/inflated reporting of support needs
- ✓ Introduction of more restrictive support
- ✓ Lack of PST member participation
- ✓ New interventions added late in the discharge planning process.
- ✓ Unprepared to provide required information at PST and pre move meetings.

v. Community Residential, Day Program or Employment Provider:

- ✓ Certification/licensing pending.
- ✓ Chosen provider not qualified to provide supports.
- ✓ Conditional License
- ✓ Required environmental modifications are not completed.
- ✓ Has not completed paperwork.
- ✓ ICF Program does not have assigned Service Coordinator
- ✓ Finding of "not a good match" on PIR from OLS or OHR
- ✓ Provider disagreement with requested/selected discharge date
- ✓ Provider determines they are unable to provide supports.
- ✓ Provisional licensed
- ✓ Reluctance to participate in the established discharge process.
- ✓ Staffing levels are insufficient to support the individual and/or needs to hire additional staff.
- ✓ Training not up to date or additional training required.

vi. Community Capacity (Lack of supports in preferred location)

- ✓ Behavioral support
- ✓ Day Support or Employment Services
- ✓ Dental or other medical providers
- ✓ Specialized Therapy Supports
- ✓ Home capacity is 5 or more (lack of more integrated options)

c. The CIM should assist with identifying and confirming the availability of community residential, day,

and employment options that are appropriate to meet the individual's needs and are in the preferred geographical area. The CIM should also communicate with the AR/SDM to address concerns and offer strategies for resolution.

d. When the CIM is unable to resolve identified barriers, the following next steps are required:
   i. Ensure an RST Referral is completed and reviewed at the next regularly scheduled meeting.
   ii. Complete the Virginia Informed Choice Form and submit along with the RST referral.
   iii. Notify the AR/SDM that a referral to the RST is being completed and explain the purpose and process.
   iv. Ensure an FRC Referral has been completed and request additional assistance as needed to identity community resources and provide education and information to the AR/SDM
   v. Confirm the AR/SDM was offered the opportunity to speak with the AR/SDM of someone with similar needs residing in the community or a Family Mentor

IV. If the AR/SDM of an individual residing at a Training Center requests that the individual be discharged to a community or DBHDS Nursing Facility (NF), the CIM will ensure the following steps are completed:

a. The designated Training Center staff member prepares the Discharge Plan and Discussion Record
b. All supporting documentation regarding the individual's needs is sent to the chosen NF.
c. Confirmation that the AR/SDM is making an informed choice after exploring more integrated community options.
d. Uniform Assessment Instrument is completed and submitted to ASCEND for completion of a Pre-Admission Screening and Resident Review (PASRR)
e. All parties are notified regarding the anticipated discharge/transfer date after receipt of a completed PASRR indicating NF care is appropriate.
f. Training Center physician completes the Recommendation for Nursing Home Care form.
g. Transportation arrangements are confirmed for the individual and their personal belongings.

V. Effective Date. 5.21.15; rev. 7.30.23

VI. References.

a. 12VAC35-115 Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department (DBHDS)
b. DI 216(RTS) 12 Training Center Responsibilities Related to Person-Centered Discharge Planning, May 1, 2015.
c. United States of America v. Commonwealth of Virginia Settlement Agreement filed in the United States District Court for the Eastern District of Virginia, Richmond Division, January 2012. Section IV Discharge Planning and Transition from a Training Center, IV.B.5, IV.B.14, Section IV.C.6, IV.D.2.a and f, IV.D.3.
d. Code of Virginia - Sections 54.1-2983, 37.2-501, 37.2-602, and 32.1-123
e. Procedure Change for the Pre-Admission Screening Process (PASRR) for Individuals Transferring from DBHDS State Facilities to Nursing Facilities — Effective March 1, 2014

VII. Attachments

a. Nursing Home Recommendation Form
b. Medicaid Memo-Procedure Change for the Pre-Admission Screening Process (PASRR) for Individuals Transferring from DBHDS State Facilities to Nursing Facilities

Recommendation for Nursing Home Care

Training Center:	Individual's Name:	NF☐	
Date of request:	Submitted by: Title:		Phone:

Reason for recommendation (complete all)

a. Describe the reason(s) for recommendation and whether the informed choice of provider process has been followed:

b. Medical Needs

c. Describe Specific Medical Concern.

d. Diagnosis	e. Prognosis

f. Specific care required that cannot be provided in a community home and why

g. Recommended length of stay in Nursing Facility Temporary or Permanent and why

h. Difficulty identifying or locating supports	i. Describe assistance needed/gaps/barriers and what has been tried and learned:
j. Other:	k. Additional comments:

Specific supports that have not been identified in the community

Skilled Nursing (RN/LPN)	☐	Medical Provider	☐	Rectal tube	☐
Oxygen/ O2 sats	☐	Trach	☐	Uncontrolled seizures/diastat	☐
Allergies	☐	Colostomy	☐	Injections for medical/behavioral	☐
Chest PT	☐	Nebulizer	☐	Pre sedation for appointments	☐
Catheter	☐	Positioning	☐	Stoma care	☐
Wound Care	☐	Blood Sugar	☐	Dislodged/leaking tube	☐
G-tube/J-tube/bolus feeding	☐	Medication by Tube	☐	Chronic constipation/enemas	☐
BP checks	☐	Other:	☐	Other:	☐

CIM Completion Only

CIM recommendations: **Facility director notified (Item e above)?** ☐ yes ☐ no	**RST referral needed.** ☐ yes ☐ no, **If yes, date of RST meeting:** **Meeting method:** ☐ conference call at: (time) ☐ in person at: (location/time)

07.30.23

Department Of Medical Assistance Services 600
East Broad Street, Suite 1300
Richmond, Virginia 23219
http://www.dmas.state.va.us

MEDICAID MEMO

TO: Directors and Staff at Department of Behavioral Health and Developmental Services (DBHDS) Behavioral Health Facilities and Training Centers and Managed Care Organizations

FROM: Cynthia B. Jones, Director

MEMO: Special Department of Medical Assistance Services (DMAS)

DATE: 2/26/2014

SUBJECT: Procedure Change for the Pre-Admission Screening Process (PASRR) for Individuals Transferring from DBHDS State Facilities to Nursing Facilities — *Effective March 1, 2014*

The purpose of this memorandum is to notify providers that the Department of Medical Assistance Services (DMAS) intends to implement a new PASRR process for both Level I and Level II screenings of individuals currently receiving care in DBHDS-licensed facilities who are ready for transfer to a nursing facility level of care.

DMAS and the DBHDS recently completed a comprehensive review of operational procedures associated with the federally mandated PASRR program. As a result of this review, DMAS and DBHDS will implement a new PASRR process effective March 1, 2014.

BACKGROUND

The Omnibus Budget Reconciliation Act (OBRA) of 1987, Part 2, Subtitle C of Title IV, added §1919 to the Social Security Act, Section 1919 (e)(7) requires states to have a preadmission screening and resident review (PASRR) program to identify individuals with mental illness, intellectual disabilities, and related conditions who are transferring to nursing facilities. Section 1919(b)(3)(F) prohibits a nursing facility from admitting any new resident who has mental illness, intellectual disability, or a related condition unless that individual has been determined by the State Mental Health Authority (SMHA) to require the level of services provided by a nursing facility. In addition, the State Mental Health Authority must determine whether active treatment and any specialized services are required. Therefore, Virginia's PASRR program includes the participation of mental health professionals and a representative from the State Mental Health Authority (DBHDS), in those cases where mental illness, intellectual disability, or related conditions are a factor.

An additional screening component is in place for individuals with a diagnosis of mental illness (MI), intellectual disability (ID) and/or a related condition (RC). The DMAS-95 MI/ID/RC Level I screening is the first step to identify MI/ID/RC for individuals seeking nursing facility placement. The Level II MI/ID/RC evaluation determines if the individual may benefit from additional specialized services but does not preclude them from receiving services in a nursing facility or a Home- and Community-Based Care Waiver that has a nursing facility as the alternative institutional placement. The first part, referred to as the Level I screening, is the preadmission screening process that determines whether nursing facility

applicants meet nursing facility level of care criteria and whether the individuals have any suspected or known mental illness, intellectual disability or related condition. The second part, referred to as the Level II is a comprehensive face-to-face evaluation of individuals with mental illness, intellectual disability or related conditions who are identified through the Level I process.

PASRR PROCESS

This memorandum identifies a procedural change for the PASRR process for both Level I and Level II. The PASRR program is a federally mandated process in which DMAS has ultimate oversight responsibility to determine if individuals with intellectual and developmental disabilities and serious mental illness, who require nursing facility (NF) level of care, meet criteria for placement. PASRR is a two-part process. The Level II evaluation is to determine if the individual may require any specialized behavioral health or other services as part of their care while residing in the nursing facility.

Federal PASRR regulations under 42 CFR §483.106(d)(1) require that an entity independent of the SMHA must conduct the Level II PASRR evaluations for nursing facility applicants and residents suspected of having a serious mental illness. To ensure the Commonwealth maintains full compliance with these regulations, effective March 1, 2014, the state PASRR third party vendor, Ascend Management Innovations LLC (Ascend), will begin conducting the PASRR Level II evaluations for individuals transitioning to a Medicaid certified nursing facility from any DBHDS behavioral health facility. To ensure uniformity, Ascend has been designated by DBHDS to conduct Level II evaluations for Virginia's training centers as well.

Due to this change, employees of all DBHDS-operated facilities will no longer be permitted to conduct Level II PASRR evaluations.

METHOD OF SUBMISSION TO ASCEND OR AUTHORIZED CONTRACTOR

All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Effective March 1, 2014, when any resident of a DBHDS-operated facility is identified for transfer to a Medicaid certified nursing facility; the DBHDS-operated facility must contact Ascend, the authorized contractor, to conduct the PASRR Level II evaluation. Ascend will evaluate individuals who have a DMAS-95 indicating MI/ID/RC and a UAI indicating ADL assistance needs and medical/nursing needs. To make a referral to Ascend, the DBHDS facility should fax the following to Ascend at 877-431-9568:

- Completed DMAS-95 Level I (dated within last 30 days)
- Completed DMAS-97 (dated within last 30 days)
- Completed UAI (dated within the last 30 days)
- Host recent History and Physical (dated within last year)
- Psychological evaluation (dated within the last year)
- Most recent psychiatric evaluation (dated within last year) containing Axis I diagnosis
- Guardianship papers, if applicable

Ascend can be reached for questions via phone at 877-431-1388 x 3206.

For individuals who require the Level II evaluation, the Ascend evaluator will telephone the designated facility contact person to schedule the face-to-face evaluation. Once onsite, the Ascend evaluator must review the individual's medical record and conduct interviews with the individual, legal guardian (if applicable), and the facility treatment team staff as part of the evaluation process.

MANAGED CARE ORGANIZATIONS

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a new initiative to coordinate care for individuals who are currently served by both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-home.aspxto learn more.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.