



STATE OF CONNECTICUT
Department of Mental Health & Addiction Services



Commissioner's Policy Statement and Implementing Procedures

SUBJECT:	Nursing Home Placement Policy
P & P NUMBER:	Chapter 6.16
APPROVED:	Miriam Delphin-Rittmon, Commissioner Date: 10/15/2015
EFFECTIVE DATE:	October 15, 2015 <i>Miriam Delphin-Rittmon</i>
REVISED:	8/15/2011, replaced Commissioner's Policy Statement No. 14 dated November 1, 1983.
REFERENCES:	Federal Register 42 CFR Part 441 (Medicaid Home and Community-based Settings) The DMHAS Commissioner's Policy Statements #6.14, 6.25, and 33 State of CT laws on conservatorship U.S. Supreme Court Decision 1999: Olmstead vs L.C. Center for Medicare and Medicaid Services Letter to State Medicaid Directors (SMDL 10-008, May 2010) re: Olmstead Compliance OBRA 1987, the Nursing Home Reform Act and the PASRR Regulations: 42 CFR 483.100-138 THE DSS & THE DMHAS Memorandum of Understanding re: PASRR
FORMS AND ATTACHMENTS:	THE DMHAS Mental Health Waiver (WISE Program) eligibility criteria and contact information. THE DMHAS Nursing Home Diversion and Transition Program contact information.

STATEMENT OF PURPOSE: The Nursing Home Policy addresses two levels of involvement by the DMHAS service system with the DMHAS clients (or the DMHAS-eligible clients) that may need nursing home level care, or may already reside in a nursing home. First, the policy defines the process by which clients are considered and evaluated for placement in a nursing home. Second, the policy stresses the system's response to the mental health needs of clients in nursing homes. The Commissioner's Policy Statements on individualized recovery planning and a recovery-oriented service system, as well as involvement of conservators of person shall guide this process along with three (3) federal directives: (1) The state's Preadmission Screening Resident Review (PASRR) Program as mandated under OBRA 1987, the Nursing Home Reform Act; (2) The U.S. Supreme Court's Olmstead Decision in 1999; and (3) Letters to State Medicaid Directors from the Center for Medicare and Medicaid Services (CMS).

Under PASRR, applicants to Medicaid-certified nursing homes must be screened to identify a diagnosis of serious mental illness (and/or mental retardation). If there is a positive diagnosis, applicants are evaluated to determine whether admission to a nursing home is appropriate. At the same time, it is determined whether applicants meet nursing home level of care criteria. PASRR also applies to nursing home residents with mental illness who experience a significant change in their physical or mental condition. Applicants to, and residents of, Medicaid-certified nursing homes must meet level of care criteria and be stable psychiatrically.

The 1999 Olmstead decision found that the requirements of Title II of the Americans with Disability Act apply to persons with mental disabilities. States must serve qualified individuals in the least restrictive, most integrated setting appropriate to their needs.

In letters to State Medicaid Directors, CMS has continually reaffirmed its commitment to policies supporting compliance with the Olmstead Decision. CMS has stated that under PASRR, states must consider community alternatives over nursing home placement – particularly for persons age 22-64.

POLICY:

1. Process for Considering and Evaluating DMHAS Clients for Nursing Home Placement:

1.1 The DMHAS staff shall ensure that clients have meaningful participation in where they will receive long-term care services and that those services are provided in the most integrated setting appropriate to the needs of the person. If applicable, a conservator of the person is involved to the extent of his/her authority. The role of any conservator should be clarified by reviewing the Court Decree, with the understanding that a conserved person retains all rights and authority not expressly assigned to the conservator in the decree. DMHAS staff shall insure that the individual's right to self-determination is respected to the full extent permitted by the Decree. DMHAS staff shall ensure that no conserved person is admitted to any institution for long term care without consideration of less restrictive alternatives and available community resources to avoid such placement and without a court order in accordance with Conn. Gen. Stat. Sec. 45a-656b. DMHAS staff shall inform conserved persons of their right to have the proposed decision reviewed by a court and make an appropriate referral to the Connecticut Legal Rights Project.

1.2 DMHAS staff are proficient in the eligibility criteria, location, and availability of all community-based long-term care housing, supports and services, including the DMHAS Mental Health Home and Community-based Services Waiver (the WISE Program), or other possible home and community-based waiver programs to assist in making a decision, clients, and conservators as appropriate, receive adequate information about all community-based options, including waivers. The overall presumption is that permanent supportive housing is the most integrated setting.

1.3 The most integrated setting shall be a setting that maximizes the individual's independence and self-determination, and opportunity to interact with persons who do not have disabilities to the fullest extent possible. They must allow individuals opportunities to engage freely in the community and community activities, and choice about providers, individuals with whom to share a room or interact, and daily living experiences such as meals, visitors, sleeping times and private communications. A setting is not integrated if it is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment or custodial care, in a building on the grounds of, or immediately adjacent to, a public institution, or a housing complex designed expressly around an individual's diagnosis or disability.

1.4 A nursing home may be considered the least restrictive, most integrated setting for a determined period of time if the following criteria are met:

- a) Client has physical, medical, and/or cognitive needs requiring 24-hour skilled nursing services (see nursing home level of care criteria below);
- b) The needs are documented in the client's record;
- c) All community options have been explored with documentation in the client's record that the needs can only be cared for in a nursing home setting; and
- d) The client's psychiatric symptoms/behaviors are stable and do not place the client or others at risk for injury.

1.5 Nursing Home Level-of-Care Criteria: There is.....

- a) The presence of an uncontrolled and/or unstable and/or chronic medical condition requiring continuous skilled nursing services as evidenced by diagnosis(es), therapies/services, observation requirements, and frequency; *or*
- b) A chronic condition(s) requiring substantial assistance with personal care on a daily basis. Substantial personal care is evidenced by one or more of the following:
 - i. Chronic condition *plus* supervision with 3 or more ADLs* daily *plus* a Need Factor**.
 - ii. Chronic condition *plus* hands-on assistance with 3 or more ADLs.
 - iii. Chronic condition *plus* hands-on assistance with 2 or more ADLs *plus* a Need Factor.
 - iv A diagnosis of a dementia, supported by corroborative evidence, and treatment for the dementia supersedes any treatment for the mental illness. The dementia must have resulted in cognitive deterioration to the extent that a structured, professionally staffed environment is needed for daily monitoring, evaluating and/or accommodating to the individual's changing needs.

ADL MEASURES:

- a. Independent/supervision less than daily: Individual independently accomplishes the activity in a way that assures health and/or requires supervision less than daily.
- b. Supervision/cuing daily: The individual requires support such as monitoring, observing, verbal or gestural prompting, verbal coaching and gestural or pictorial cuing in order to accomplish the task. The support is needed daily. No hands on support are needed.
- c. Hands-on support: Physical assistance from another person is needed to initiate or complete the task or activity in a way that assures health and safety. Even with diligent verbal or gestural cues, the individual requires physical assistance or intervention to accomplish the task.
- d. Total Dependence: The individual is incapable of performing the task without assistance of another person or persons.

NEED FACTORS:

- a. A rehabilitative service 5 times per week (PT, OT, ST, RT) and the individual is determined to have restorative potential.
- b. Requires the presences of a caregiver daily for supervision to prevent harm due to cognitive impairment, with severe deficits evidenced by impairments in one or more of the following areas: memory; orientation; judgment; communication.
- c. Due to a corroborated diagnosis of dementia, the individual requires the presence of another person at least daily for supervision to prevent harm due to one or more of the following: Abusive/Assaultive behavior; Unsafe/Unhealthy Hygiene/Habits; Wandering; Threats to Health/Safety.
- d. Requires the assistance of another for administration of physician-ordered daily medications. Assistance includes supports required beyond set ups and may include verbal or gestural supports (e.g., instructions, coaching, pointing) – or physical assistance with some or all of the physical steps of taking daily prescribed medications.

- 1. **1.6** The client's clinical condition and need for services must fit the specific nursing home in terms of nursing services, ancillary services, environment, activities, and behavioral control. Discharge planning personnel have firsthand knowledge of the nursing home. The client and/or conservator and/or family, as appropriate, are oriented to possible specific placements, preferably by visit, and participate in the final selection and agree to the placement. Keep in mind that a conservator should be involved only to the extent authorized by the court order setting out his/her duties and responsibilities. (see 1.1)

1.7 The DMHAS staff shall adhere to Federal and State Preadmission Screening Resident Review (PASRR) requirements as specified by the State Medicaid Agency, CT Department of Social Services and the DMHAS.

1.8 The DMHAS staff shall review the contents of the PASRR outcome letter. For clients meeting nursing home level of care and approved for admission, the nursing home length of stay is specified in this letter. Be aware that the length-of-stay is most often short-term (i.e., 30; 90; 180 days; etc.), which means the client will require discharge planning back to the community.

- a) If the client is approved for a short-term stay in a nursing home, DMHAS staff communicate their involvement to the DMHAS Nursing Home Diversion and Transition Program (NHDTP) Manager, and/or if known, the appropriate NHDTP Nurse Clinician. The DMHAS staff and the NHDTP Nurse Clinician collaborate with nursing home staff on appropriate discharge planning and transition to the community with supports. *NOTE: As much as possible, the community agency serving the client preserves existing housing (e.g., apartment or DMHAS-funded residential program bed) to facilitate the client's return to the community.*
- b) If the client is denied access to a nursing home bed because he/she does not meet nursing home level of care criteria, the DMHAS staff is responsible for developing an alternative care plan. If the denial for nursing home admission occurs while the client is in an acute hospital bed or the hospital emergency department, or a nursing home bed, the DMHAS staff shall collaborate with hospital staff regarding a safe, orderly, and appropriate discharge plan.
- c) If the client is denied access to a nursing home bed because he/she requires specialized mental health services (*defined as acute psychiatric care in a hospital setting*), the State (*per federal regulation*) is responsible for providing or arranging for that level of care.

1.9 For a client entering a nursing home for any length of stay, the DMHAS staff shall follow-up for appropriateness and adaptation within two weeks of admission and periodically thereafter as appropriate. If available, the NHDTP Nurse Clinician may assist with this follow-up and monitoring process.

2. Responding to the Mental Health Needs of Clients in Nursing Homes

2.1 The DMHAS service system responds promptly to calls from nursing home staff, hospitals, or others when a client, or DMHAS-eligible client, has an identified need from the community mental health system.

2.2 Nursing home clients transitioning to the community may require an appointment to establish community mental health services. The standard is to establish this appointment within the first week of the client's discharge from the nursing home. Whenever possible, the NHDTP Nurse Clinician assists with this process.

2.3 Nursing home clients transitioning to the community may apply to the DMHAS-supported community housing programs. Housing staff responsible for the application process respond promptly to calls from nursing home staff, the NHDTP Nurse Clinician, or others working with the client to minimize delays in securing appropriate community housing.

2.4 For clients transitioning from the nursing home to the community, all community-based services and supports are available to the client within a reasonable period of time, not to exceed 120 days from the date the client chooses the supports and services.

* **ADLs (Activities of Daily Living):** Bathing; Dressing; Eating; Toileting; Continence; Transferring; Mobility. *NOTE: Supports needed for eating exclude those needed for meal preparation or for supervision of obesity or weight reduction.*

** **NEED FACTORS** as described on page 2

**Department of Mental Health and Addiction Services
Nursing Home Diversion and Transition Program (NHDT)**

Goal: To ensure that DMHAS clients are not placed in, or remain in, nursing homes unless necessary, appropriate, and safe. Preadmission Screening Resident Review (PASRR) is an integral part of the program.

Objectives:

- 1) Divert DMHAS clients from nursing home placement unless absolutely necessary (i.e.; person could not be served in the community due to a need for continuous skilled nursing services related to a chronic condition, or requires short-term rehabilitation for a medical condition).
- 2) Transition back to the community DMHAS clients who reside in nursing homes and no longer require the level of care.

NHDT Program Structure:

- 1) Program is "housed" in the DMHAS Older Adult Services Unit.
- 2) Staff includes a Program Manager, Nurse Clinicians, and a Case Manager .The Nurse Clinicians and Case Manager are located at DMHAS-operated or –funded agencies (see Attachment for names of the clinicians, coverage areas, and contact information).

Nurse Clinician Functions: (see Appendix for staff contact information)

- 1) Work directly with community providers, nursing homes, and discharge planners (both inpatient and in emergency rooms) to determine the appropriate level of care for DMHAS clients.
- 2) Act as liaisons for clients eligible for DMHAS services through Local Mental Health Authorities and the Mental Health Waiver, as well as other initiatives (e.g.; Money Follows the Person or PASRR) or agencies providing services to clients.
- 3) Link with PASRR Program by assisting DMHAS and other providers in determining whether client applying to a nursing home meets level of care criteria, and for clients who enter a nursing home with a short-term approval, monitor and track length of stay for possible transition to the community.

QUESTIONS?

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WISE

Working for Integration Support and Empowerment

The Mental Health Home and Community Based Services (HCBS) Waiver

This waiver program for individuals with serious mental illness encompasses the recovery orientation adopted by the Department of Mental Health and Addiction Services (DMHAS), but also signals new directions in the community treatment of people with serious psychiatric disabilities because of its emphasis on:

- Intensive psychiatric rehabilitation provided in the participant's home, and in other community setting;
- Attention to both psychiatric and medical needs;
- Emphasis on wellness and recovery;
- Person-Centered Planning leading to development of an individualized Recovery Plan; and
- Use of peer supports provided by people trained and certified in rehabilitative care, who know from first-hand experience about recovery from mental illness.

The waiver program, authorized in §1915(c) of the Social Security Act, permits the State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutional care. Waiver services complement and/or supplement services available to participants through the Medicaid State plan and other federal, state and local public programs, as well as natural supports that families and communities provide.

The Waiver will serve 216 individuals (72 new participants each year) who are currently in nursing facilities or who are at risk for this level of care. The Waiver is operated by the DMHAS with oversight by the Department of Social Services (DSS). The Waiver began on April 1, 2009.

Each person enrolled in the waiver participates in a Person-Centered Planning process leading to the development of an individualized Recovery Plan. The plan, developed collaboratively with the participant and a DMHAS Community Support Clinician includes one or more of the following services:

Rehabilitative Services:

- **Assertive Community Treatment (ACT)** – intensive clinical and rehabilitative care provided by an interdisciplinary team; nationally recognized as an “Evidence-Based Practice.”
- **Community Support Program (CSP)** – a flexible, team-based approach to community rehabilitation.
- **Peer Support** – a “step-down” and follow-up to ACT or CSP provided by a trained and certified peer specialist (i.e., a person who understands mental illness and recovery from his/her own personal experience).
- **Supported Employment** – an effective array of mental health supports designed to help participants find and sustain competitive employment.

Support Services:

- **Recovery Assistant** – homemaker, companion, personal care, and in-home respite services designed to help a participant maintain his/her own home.
- **Transitional Case Management** – services provided during the weeks prior to, and immediately following discharge from a nursing home, to help locate and set up a suitable apartment or other living arrangement.
- **Short Term Crisis Stabilization** – services designed to stabilize a participant in an emerging crisis situation.

Other Ancillary Services:

- **Specialized Medical Equipment**
- **Home Accessibility Adaptations**
- **Non-medical transportation**

Client Eligibility for Mental Health Waiver

Must meet **all five** eligibility requirements as listed below:

1. 22 years of age or older;
2. Medicaid eligible;
3. Meets the Medicaid criteria for nursing home level of care;
4. Voluntarily chooses to participate in the waiver; and
5. Has a diagnosis of serious mental illness

Is currently a resident of a nursing facility

OR

Living in the community and being diverted from admission and has a history of:

- Two or more inpatient psychiatric hospitalizations in the past two years; **or**
- A single inpatient psychiatric hospitalization lasting 30 days or more in the past two years; **or**
- Three crisis episodes in the past year requiring face-to-face assessment

Additional Considerations

- Health and safety needs can be reasonably assured
- Two or more waiver services required
- Waiver services cannot be provided to individuals living with 4 or more unrelated persons.
- Cost of the waiver services is expected to remain within the cost limit established by the state (NOTE: cost limits do not support 24-hour care)
- Income limits for Medicaid up to 300% of poverty level- reduces occurrence of Spend Down.

MH Waiver Application – Referral Process

1. Application/ Request for Service submitted to MH Waiver Program
2. Medicaid eligibility verified by DSS
3. Assessment conducted by a Waiver Community Support Clinician (CSC)- to confirm eligibility
4. Recovery Plan developed including: services needed, assurance of cost neutrality and community safety
5. Plan and corresponding services submitted by Waiver staff to DSS for approval
6. Recovery Plan implemented with Waiver Service Providers selected by participant
7. Payment for Services as outlined in Recovery Plan are authorized by Waiver Staff- reviewed quarterly

Contact Megan Goodfield (860) 262-6953 or toll free 1-866-548-0265