Skilled Nursing Facility Coordination and Transition Supports

June 9, 2023

Skilled Nursing Facility Coordination and Transition Supports – Implementation Planning

The Skilled Nursing and Facility Coordination and Transition Supports is a collaboration with EOHHS, MassHealth, and EOEA to enhance and expand programs to increase access to behavioral health services to nursing facility residents and support their transition to the community. The programs include:

- Building on PASRR (Pre-Admission Screening and Rresident Review) process.
- Expanding DMH eligibility to all individuals with a positive PASRR Level II determination.
- Creating a DMH Nursing Facility Transition unit to include NF Transition Manager, NF Nurse Specialist, NF Transition Case Manager Supervisor and Transition Case Managers.
- Leveraging BH CP for the coordination of behavioral health and specialized services for individuals with positive PASRR Level II in nursing facilities.
- Assigning DMH Transition Case Management services for individuals with a 90 day determination to facilitate transition/discharge activities from NF to community
- Developing a new Enhanced Medical Group Living Environment to provide nursing and hands-on care in the community.

PASRR

- Applies to all individuals applying for admission into a nursing facility
- Prevent individuals from being unnecessarily institutionalized.
- Identify individuals with a PASRR condition –SMI/ID/DD
- Ensure that NF residents with SMI receive appropriate care including behavioral health services and/or specialized services
- Identify residents with SMI who may no longer be appropriate for SNF and may be better served in a less restrictive setting.

- **Level I** Preadmission Screen to identify individuals seeking admission to a nursing facility that have, or may have SMI.
- **Level II** conducted for all individuals identified with positive Level I screen.
- **Level II** requires three distinct determinations:
    - Does the individual have SMI?
    - Is a community placement more appropriate than a nursing facility placement?
    - If nursing facility placement is best, does the individual require “specialized services” or other behavioral health services?

DMH Nursing Facility Transition Team

- **DMH NF Transition Manager**
  - Oversight for all assessment, service coordination and transition planning including the PASRR program and coordination of specialized services by BHCP and other Integrated Care Coordination resources.
  - Manages the coordination and oversight of the DMH Transition Team assigned to NF's to facilitate community transitions.

- **DMH NF Transition Specialist**
  - Provides clinical support and consultation to the PASRR evaluation team, BH CPs, Transition Case Management team
  - Consults with DMH continuing care units and community services to assess needs for individuals who may be diverted from NF placement

- **DMH Transition Case Manager Supervisor**
  - Direct supervision of the DMH NF Transition Case Managers
  - Implement decisions made through the PASRR process
  - Assign individuals to transition case managers

- **DMH NF Transition Case Manager**
  - Provide state wide case management services and lead discharge planning and service coordination activities to support community transitions or diversion of individuals from NF and to ensure a smooth transition to the community.

PASRR and DMH Transition Team

The UMass PASRR team completes a Level II evaluation at multiple points in an individual's stay in a nursing facility.

- At admission to the nursing facility
- When there is a significant change in the status of the individual
- Every 12 months for individuals with SMI who are determined to need nursing facility level of care.

90 Day Approval: Individual may be more appropriate for a community placement

- DMH will assign a DMH Transition Case Manager to individuals with a 90 day approval to coordinate the person's transition from the SNF to the community, including:
  - Work with existing Care Coordination services (BH CP, One Care plan, etc)
  - Collaborate with the DMH Site Office to facilitate referral and enrollment into DMH services
  - Assist with Referrals to other community services and supports (PCA, VNA, home modifications, etc.)
  - Coordinate Discharge Date with SNF

12 Month Approval: Individual needs nursing facility level of care for 12 months

- DMH will refer to BH CP for individuals with a 12 month approval for care coordination and coordinate specialized services and other appropriate behavioral health services.

ACCS Expansion to Support NF Transitions

- Created an Enhanced Medical Group Living Environment to provide nursing and hands-on care in the community.

- Higher level of care than the current ACCS Intensive Medical GLE.

- Services are designed to meet and support the daily needs of individuals with chronic medical conditions, terminal illnesses and/or disabilities which are impacted by their significant mental illness.

- Individuals referred to this program do not meet the criteria for skilled nursing facilities, acute hospitalization or Intensive Medical GLE (IMGLE), however still require licensed and unlicensed professional services to meet their chronic complex medical and behavioral needs to ensure improvement or stabilization of their medical and behavioral condition.