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Assessment #6

Improving Community Options for Older Adults

September 2016

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Health*

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Improving Community Options for Older Adults

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Executive Summary

Approximately 18.1 percent of the US population had a mental health condition in the past year and 4.1 percent had a serious mental illness.¹ With a rapidly growing older adult population, the need for long term services and supports (LTSS) and specialty mental health care will continue to increase. Dovetailing with the change in demographics is a national effort to improve and expand community based options for LTSS and reduce reliance on institutional long term care settings such as nursing facilities. This national effort is called “rebalancing.” Two federal programs—the Preadmission Screening and Resident Review (PASRR) program and the Aging and Disability Resource Centers (ADRCs) can be utilized by states to assist in “rebalancing” efforts. PASRR requires states to screen every person referred to a Medicaid-certified nursing facility who has or is suspected of having a mental illness, intellectual disability or related condition to determine that they are placed in the most appropriate setting of their choice and to ensure that they receive proper supports and services in that setting. ADRCs are part of a state’s No Wrong Door (NWD) System and have been created as an entry point to community based LTSS. Linking the PASRR screening and assessment with the community resource function of organizations such as ADRCs, as seen in the person-centered counseling model, has great potential to complement and strengthen states’ rebalancing efforts.

Incorporating the use of technology to streamline the PASRR process, as seen in Indiana and Utah, has several benefits including: timely and efficient communication between hospitals, nursing facilities and community partners, such as ADRCs; quicker referrals to long term services and supports; and reduced hospital stays.

In addition to the promising practices of Indiana and Utah regarding the use of technology, Wisconsin also offers an important example of a state with a concrete relationship between the PASRR program and the state’s ADRCs, albeit with a paper-based system. Wisconsin is a state cultivating improved communication efforts between the aging, mental health, and nursing facility staff, and these efforts shall be discussed in greater depth herein.

As states rebalance their LTSS systems, they should look toward enhancing and more closely linking their PASRR and NWD System processes and systems. In addition to formal memorandums of understanding, cross-training, and updating of policies, states should consider implementing and linking electronic web-based systems for their PASRR and NWD System. Linking the PASRR process with resources in a NWD System, especially with efficiencies available through electronic systems, can improve access to community based LTSS for older adults and adults with disabilities, and divert or reduce the length of nursing facility admissions. By working towards a direct relationship between PASRR and a state’s larger access system for all populations and payers, individuals’ lives will be enhanced by an optimal process to provide for their LTSS needs, especially those who

¹ Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from <http://www.samhsa.gov/data/>.

desire community living.

Presenting Challenge to States and Providers

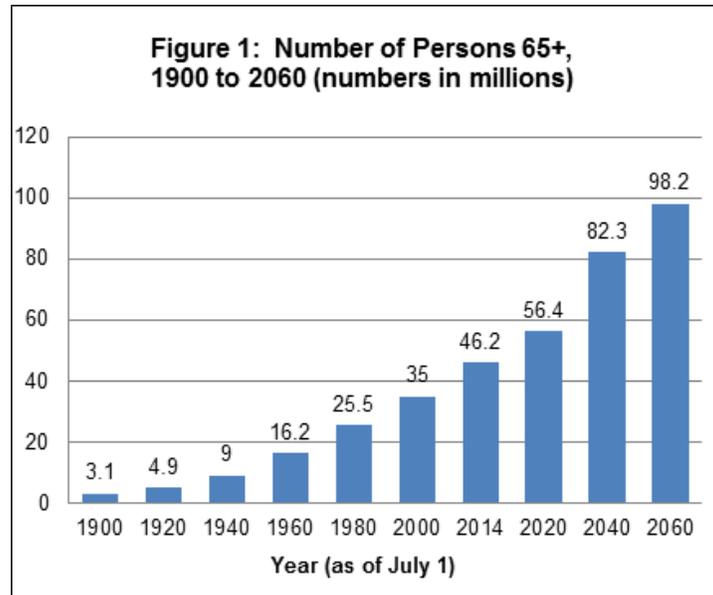
Ensuring that older adults with mental health or behavioral health needs are in the most appropriate setting of their choice for long term services and supports (LTSS) is a goal that many states strive to achieve through their Preadmission Screening and Resident Review (PASRR) program and by connecting to a state's broader access system to LTSS system. Based on recent survey findings from the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of States United for Aging and Disabilities (NASUAD), there appears to be consensus from both organizations that better coordination between PASRR and local Aging and Disability Resource Centers (ADRCs) may lead to better long term care services for adults 65 and over and individuals with disabilities who have behavioral health, physical health, and community living needs. A NASMHPD survey of the Older Persons Division representatives found that almost 28 percent of the responders didn't have an existing system in place to create a linkage between the PASRR program and local ADRCs. Likewise, NASUAD surveyed its members and found that only a third (33 percent) reported that their access system coordinates with the PASRR process. The survey findings illustrate the need for better coordination between the PASRR and a state's access systems. Results also indicated that when a paper process is used, the evaluation process can take significantly more time to complete, making opportunities for efficient transmission of information and coordination with a state's access system harder and less likely to occur.

This paper explores opportunities for state mental health authorities and state agencies on aging and disability to develop a real-time approach for collaboration between the PASRR and organizations in a NWD System. Specifically, this paper highlights three promising practices that focus on streamlining processes and enhancing integration of PASRR and a state's access system. For example, Utah and Indiana have shown innovative efforts to improve the application and referral process by moving from a paper-based PASRR practice to a secure electronic/web-based system; this new electronic process has eliminated the time and cost challenges associated with a paper-based PASRR system. Wisconsin is an example of how a state directly connects its PASRR and the state's access system through a paper-based PASRR process. These partnerships between systems is essential for the progression in developing best practices to serve older adults and individuals with disabilities. Better coordination between states' PASRR processes and a state's NWD Systems will better serve older adults and individuals with disabilities who have behavioral health, physical health, and community living needs. Real-time collaboration between PASRR and a state's NWD System is a promising practice for improving efficiencies, shortening hospital stays, and helping divert institutional nursing facility stays which results in a more person-centered planning process.

Demographics of Older Adults

The United States' older adult population (i.e., persons age 65 and older) will continue to grow dramatically in the upcoming years. The most recent U.S. Census data found that there was a 28 percent increase in the older adult population in the last decade—36.2 million in 2004 to 46.2 million in 2014. About one in seven Americans is an older adult. As Figure 1 illustrates, it is projected that by 2060 there will be about 98 million older adults, almost doubling the number of older Americans from 2014.

Figure 1: Number of Persons 65+: 1900-2060 (numbers in millions)



Note: Increments in years are uneven.

Source: U.S. Census Bureau, Population Estimates and Projections.

The population 65 and over represented 14.5 percent of the U.S. population in 2014 and is projected to increase to 21.7 percent of the population by 2040. This changing demographic will have a significant impact on LTSS systems provided by state Medicaid programs, mental health agencies, and state agencies on aging and disability. Karel, Gatz & Smyer's research indicated that an estimated 20.4 percent of adults 65 and older met criteria for a mental health condition, such as depression and dementia, during the previous year.² To ensure that older adults are receiving LTSS in the most appropriate and integrated setting of their choice—a movement that started in the 1960's—can be seen in a state's PASRR program and a state's access system to LTSS.

PASRR: Background and Overview

² Karel, M. J., Gatz, M., Smyer, M. (2012). Aging and mental health in the decade ahead: What psychologists need to know. *American Psychologist*. Vol. 67 (184-198).

President Kennedy’s de-institutionalization movement towards community integration for individuals with mental illness was the first of several federal policies to transform the public mental health system. Since the Community Mental Health Act was signed into law by President Kennedy in 1963, other federal policies have also sparked major transformation of the mental health system. These policies include the creation of the Preadmission Screening and Resident Review (PASRR) program in 1987, the Americans with Disabilities Act of 1990, and the 1999 Supreme Court ruling of *Olmstead v. L.C.* that requires states to serve qualified individuals “in the most integrated setting appropriate.”

PASRR was created in 1987 through the Omnibus Budget Reconciliation Act (OBRA), also known as the Nursing Home Reform Act, and went into effect January 1, 1989. The authors of the PASRR legislation wanted to ensure that individuals with a mental illness (MI), intellectual disabilities (ID) or related conditions (RC) were:

- Identified if they were a nursing facility applicant or resident;
- Placed in the appropriate setting of their choice, whether that setting is in their home or in a nursing facility; and
- Provided the services they need in those settings.

The *Olmstead* ruling provides guidance for placement determination in the least restrictive setting of an individual’s preference—whether in the community or in a nursing facility—and to ensure that the individual receives proper supports and services in that setting. Given its unique importance in Medicaid law, PASRR is instrumental in state LTSS systems ensuring that individuals are properly placed and receiving services in that setting, thereby helping states comply with the American with Disabilities Act (ADA) and *Olmstead* requirements. In brief, PASRR is an important tool to help states rebalance services away from institutional care to community based options for LTSS; the PASRR process promotes person-centered planning to assure that an individual’s mental and functional needs are being considered along with their personal goals and preferences in planning for LTSS.

PASRR is considered a special administrative activity, and has been deemed by the Centers for Medicare and Medicaid Services (CMS) as a mandatory part of the basic Medicaid State Plan. Under the Medicaid law, [42 CFR 483.100-138](#), states are required to assess all individuals prior to being admitted to a Medicaid-certified nursing facility. If an individual is suspected to, or has a MI, ID, or RC, then a referral is made to determine if a PASRR evaluation is needed, known as the Preadmission Screening (PAS). Following the admission, the Resident Review (RR) may need to be completed based on the individual’s needs and the criteria outlined in the [Code of Federal Regulations](#). The purpose of the RR is to ensure that nursing facility residents are getting their service needs met; thus, the state must systematically review the MI, ID, or RC status of nursing facility residents to determine if a significant change in their condition has occurred. If a significant change in their MI, ID, or RC status has occurred, then the nursing facility is encouraged to contact the appropriate state agency (mental health or intellectual disabilities) for further screening.

PASRR incorporates two core components: Level I screening and Level II evaluation. The aim of the Level I screening is to identify individuals who might have a PASRR condition—MI, ID, or RC. All nursing facility applicants, regardless of the payer, are given a Level I

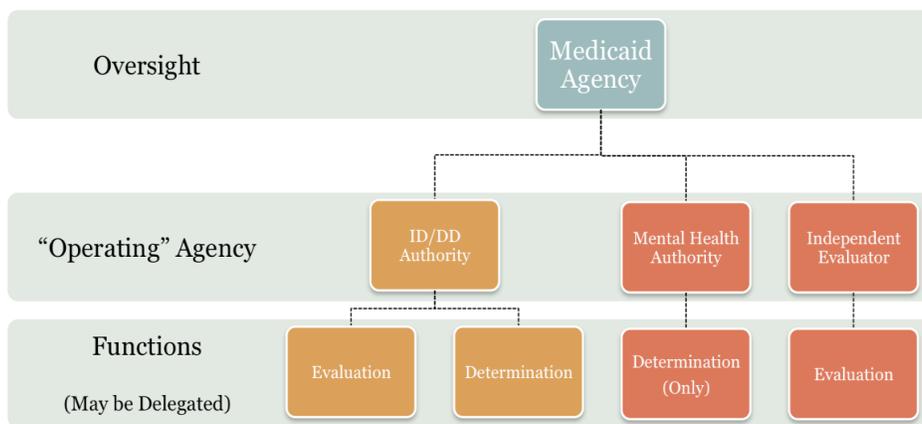
screening to determine whether the applicant may have a PASRR condition. Level I screenings can be administered by hospital discharge planners, social workers, nursing facility staff, or other health officials determined by each state’s criteria.

An applicant who tests positive at Level I for suspicion of a MI, ID or RC will be referred for a more in-depth Level II evaluation. The Level II evaluation will determine if the applicant has a PASRR condition; determine if the applicant needs nursing facility level of care; and evaluate if the applicant requires “specialized services” or “specialized rehabilitative services” and if the current or requested nursing facility can provide those services as part of its core services to meet the applicant’s PASRR-related specific needs. The Level II evaluation includes: a report of the individual’s medical needs, psychiatric history; history and physical administered by a physician; a functional assessment (e.g., activities of daily living and instrumental activities of daily living); a history of medication and drug use; and a psychiatric assessment and history performed by a qualified examiner as defined by each state.

The Role of State Agencies

PASRR’s administrative activities are shared by three different state entities: (1) the state Medicaid authority, which ultimately has the responsibility for overseeing each state’s PASRR program; (2) the state mental/behavioral health authority (SMHA), which typically issues Level II determinations but doesn’t have the authority to perform Level II evaluations (frequently contracted to a separate entity as determined by the state); and (3) the state intellectual disability authority, which oversees Level II evaluations and determinations, or it can delegate these administrative activities.

Figure 2



Source: Technical Assistance Center

Another vital stakeholder agency to support the PASRR process is the state agencies on aging and disability, which typically oversees programs such as the ADRCs, Area Agencies on Aging (AAAs), Centers for Independent Living, and services for older adults, individuals with disabilities and their caregivers so they can live a meaningful and enriching life in their

community with their friends and family. Across the country many community members find the process to obtain LTSS confusing and burdensome. To streamline the process, the federal government continues to support states' effort to enhance their current access to LTSS, which are operated in some form or fashion in all fifty states and the District of Columbia.

ADRCs: Background and Overview

The Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) awarded ADRC grants to 12 states in 2003, and each year the number of states participating in the program grew with eventually all states and several territories receiving funding to develop ADRC programs. As the number of participating states grew, the ADRC initiative started to evolve, and several key functions were strengthened. For example, in 2007 CMS made special Hospital Discharge Planning grants available to 10 state ADRC programs to strengthen their involvement in hospital to home care transitions. Then, in 2009, supporting care transitions was recognized as a functional component of the ADRC initiative. This work expanded again in 2010 when AoA made special grants available to 16 states to partner with hospitals to build evidence-based care transition programs into their ADRC programs. States received funding to demonstrate innovative ways to implement care transitions and person-centered practices within the context of their ADRC work. The capacity of ADRCs to help nursing facility residents transition back to the community was significantly bolstered when state Medicaid agencies started to invest in ADRCs to assist with Money Follows the Person (MFP) transitions. MFP is a CMS-funded demonstration grant program to support states in transitioning Medicaid beneficiaries from an institutional setting to home and community-based settings. Under CMS guidance for [Minimum Data Set \(MDS\) Section Q](#), many Medicaid agencies designated ADRCs to serve as a Local Contact Agency (LCA) to assist nursing home residents expressing a desire to return to the community.

Another major development in the evolution of the ADRC model occurred in 2008 when the Veterans Health Administration (VHA), the nation's largest health care system, recognized the value of ADRCs in helping consumers develop person-centered plans (PCP) and direct their own care. In that year, the VHA entered into formal funding agreements with ADRCs to serve as the VHA's designated entity for delivering the Veterans-Directed Home and Community Based Services Program (VD-HCBS). Another development in 2008 included Nursing Home Diversion/Community Living grants to strengthen the role of the ADRC in serving non-Medicaid eligible individuals in an effort to reduce the rate that they spend down to Medicaid by diverting them from more expensive LTSS. Then, in 2010, the Patient Protection and Affordable Care Act (ACA) provided \$50 million dollars over five years to support the further development of the ADRC program. The ACA also funded the CMS Balancing Incentive Program to incentivize states to rebalance their Medicaid LTSS spending and required participating states to make changes to their LTSS systems, including developing a statewide No Wrong Door System. Many state Medicaid agencies included ADRCs in the development of their Balancing Incentive Program NWD System.

In 2012, recognizing the accomplishments of both the ADRC and Balancing Incentive programs, as well as the lessons learned from the experience of states participating in these and other LTSS initiatives, the Administration for Community Living (ACL), CMS, and the VHA issued a new Funding Opportunity Announcement (FOA)—known as the 2012 “Part A: The Enhanced ADRC Options Counseling Program”—that reflected the key lessons learned to date. One of the major learnings reflected in the announcement was that no one agency or network could successfully implement a LTSS access system for all populations and all payers without having multiple agencies and organizations at the state and local level formally involved in the system’s operations. Many different agencies and organizations that serve or represent the interests of different LTSS populations need to be involved. The new FOA embraced this lesson by officially adopting the “No Wrong Door” model.

Another learning reflected in the FOA was the key role the state Medicaid agency needed to play in the development and financing of a NWD System. Eight states (Connecticut, Massachusetts, Maryland, New Hampshire, Oregon, Vermont, Wisconsin and Washington) were awarded grants to develop a NWD System for all populations and all payers and to work with the federal partners on the development of national standards and tools, including a national training program on Person-Centered Counseling, that could be used by all states to develop NWD Systems for their citizens. In 2014, building on the work of the eight Part A states, ACL, CMS and VHA awarded 25 states and territories one-year grants to develop three-year implementation plans that will guide the transformation of their multiple LTSS access programs and functions into a single statewide NWD System for all person regardless of age, income or disability. Most recently, in 2015, five of the 25 states were provided additional funding to transition from planning to implementation of their NWD System. With the on-boarding of these five additional states, it brought the total number of active states to 13 which are implementing an aspect of their NWD System.

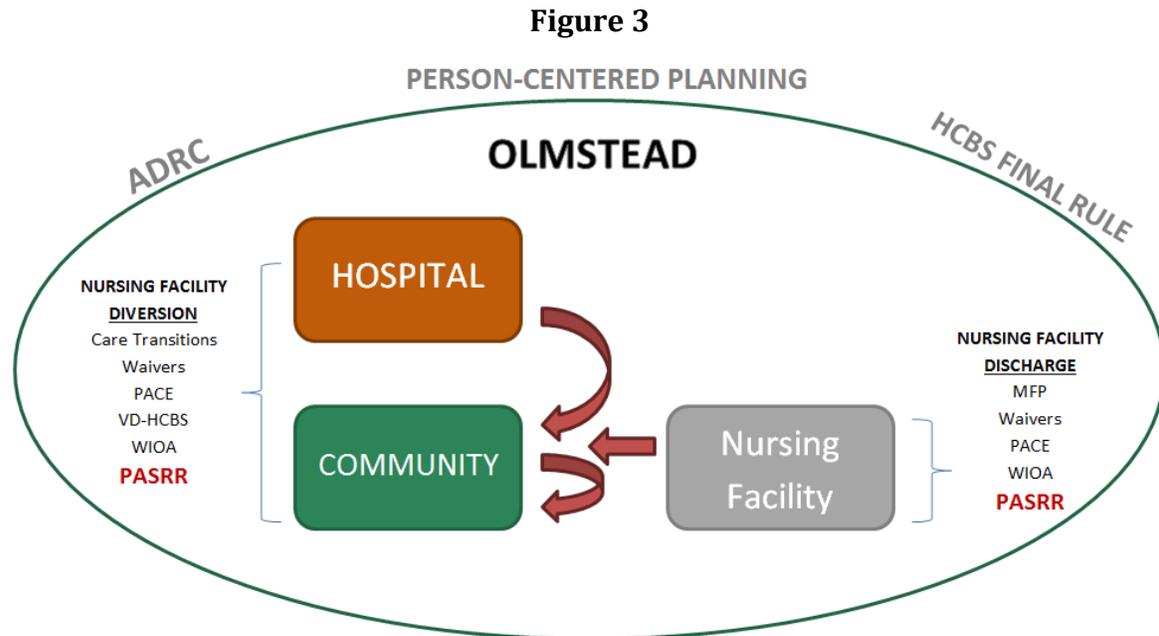
Person-Centered Counseling: Linking PASRR to LTSS

The person-centered counseling (PCC) model, also known as options or choice counseling, is the process where individuals and their loved ones are given support to develop a person-centered plan for their LTSS needs while considering the individual’s situation, preferences, and resources. Option counselors: conduct a person-centered interview; assist with the development of an action plan to help the individual implement; assist the individual and their loved ones to connect with resources and services; and provide follow-up to ensure that the individual is meeting their plan’s goals and accessing services.

PCC is an innovative approach that many states are implementing to link their PASRR and ADRC systems to ensure that individuals are living in the most integrated setting of their choice for their LTSS needs. As Figure 3 illustrates, PCC can assist in “Preadmission Screening” to divert individuals from being inappropriately placed in a nursing facility when community living is desired. Furthermore, PCC can be highly beneficial in shortening nursing facility stays and helping individuals who are being discharged from the nursing facility by connecting them with resources and services. The PCC model is a tool that can assist states in their rebalancing effort as a means to expand home and community-based options for LTSS.

Innovative Practices: Utah, Indiana and Wisconsin

The member survey conducted by NASUAD and NASMHPD in July 2016 identified three promising practices highlighted in three states: Utah, Indiana, and Wisconsin. Each state has taken specific and focused steps on streamlining processes and enhancing integration of PASRR and ADRC systems.



Source: PASRR Technical Assistance Center

Utah

The effectiveness and efficiency of an electronic PASRR process can assist in expediting individuals with MI, ID, or RC being referred for much needed services and supports much sooner than with a paper process. Utah in 2007 created a secure web-based electronic process to automate all of the PASRR evaluations and develop an electronic billing system. The Utah Division of Substance Abuse and Mental Health (DSAMH) began a two year process in collaboration with 100 nursing facilities and over 60 evaluators during fiscal year (FY) 2007. As described by DSAMH, the PASRR program's manual paper system was inefficient. Examples of this inefficiency included:

- All evaluations were hand-written documents consisting of up to 50 pages of information for each patient that had to be mailed or faxed to DSAMH for review, leading to delays with processing;
- DSAMH required two full time staff to administer the PASRR program—a licensed clinician and a full time administrative staffer; and
- The state lacked efficient systems for tracking PASRR evaluation results and decisions.

DSAMH's new electronic system has greatly improved tracking and reporting capability for the agency by allowing invoices to be created based on the evaluations being recorded in the secured web-based system. This new system has also improved the processing of evaluations. While still using the paper-based process, Utah processed 1694 Level II evaluations in FY 2007. But, after the electronic process was implemented, during FY 2009 and FY 2010, DSAMH processed a combined 4,218 PASRR Level II evaluations that has allowed quicker process times. The number of evaluations being completed continues to increase as the older population increases as evidenced by processing 3,104 Level II evaluations in FY 2015 and 3182 in FY 2016, which is nearly double the number processed on the old paper-based process. And, due to the efficiency of the electronic PASRR process, it is now managed by a half time licensed clinician and a half time support staff. DSAMH importantly points out that state costs declined due to individuals being transitioned faster from the hospital to a nursing facility which also improves the individual quality of care. The turnaround time for Utah PASRR Level II evaluations of nine business days under the paper process has improved to two business days under the new electronic system.

In addition to the improvements with PASRR, DSAMH is working toward bridging PASRR and the ARDCs with the state's rebalancing effort. This will be done by using the secure web based system through collaboration and sending an automated secure email to the nursing facilities and the ARDCs to help facilitate community integration.

Indiana

Indiana has recently implemented a new system to automate the PASRR process. The state phased out a 30 year old paper-based PASRR process for an electronic PASRR system in collaboration with the Indiana Division of Mental Health and Addiction (DMHA) and the Division of Disability and Rehabilitative Services (DDRS). Also involved with the collaborative efforts are the state hospital association, the state's nursing industry, and the state's Area Agencies on Aging (AAA) that encompasses their access system. The focus of the redesign was to: create a system that is person-centered for individuals to provide input regarding a desired outcome; have statewide standardization to build consistency and to create a more efficient, timely process. The system, known as AssessmentPro, which is provided through Ascend Management Innovations, a subsidiary of Maximus, now has 700 plus facilities using the system (nursing facilities and hospitals). This equates to over 4,000 individual users of the Indiana PASRR system. The automation of the system will provide savings to Indiana in both time and cost by linking the PASRR system to the state's Medicaid Management Information System (MMIS), and will lead to quicker timelines, fewer errors, and better data analysis.

The new system went live on July 1, 2016 and includes many benefits and upgrades to the PASRR process. The system reduced processing timelines of PASRR Level I and Level II reviews to within six business hours, and even more immediate if a clinical review is not required. Examples of improvements in the process include:

- Hospital discharge planners have 24/7 access to the system, and if there are no indicators of mental illness or intellectual disabilities per the algorithm in the system,

- the hospital will receive immediate approval from the system to allow the individual to proceed to discharge;
- The system has improved accuracy of evaluations with a more comprehensive Level I screening tool and reduced the number of false negatives resulting from the Level I screening;
 - Eventually the new system will be able to track the overall nursing facility census with much greater accuracy in data; and

At the same time of these PASRR advances, Indiana sees the importance of building that link to their broader access system. Indiana is engaged in a marketing initiative to create a statewide identity for their statewide access system, INconnect Alliance. In the spring of 2016, Indiana launched a website, INconnectAlliance.org, which is anticipated to become a “virtual ADRC” over the course of several phases. The state is looking to build this “virtual” system as a way for consumers to easily acquire information that they need on their own, and then make contact to a local ADRC to provide more assistance as it is needed. As an aspiration, Indiana, with the new PASRR system in place, can look at the feasibility of certain events in the PASRR process triggering a referral to a local ADRC as well.

Wisconsin

There are clear benefits to states implementing an electronic PASRR process with ADRCs as illustrated in Utah and Indiana. Some states may be constrained by budgetary and IT infrastructure, making it challenging for those states to implement an electronic process. The relationship between PASRR and ADRC systems are a critical component to effectively screen, refer and provide information to community members. An example of the PASRR program and local ADRCs being directly connected, albeit by a paper process, is found in Wisconsin. The state has developed at least one county PASRR liaison for each of its 72 counties; some counties have assigned two liaisons: one deals with individuals diagnosed with mental illness and the second one handles cases involving individuals with developmental disabilities. The county PASRR liaison—who are sometimes an ADRC or Adult Protective Services (APS) staff member—oversees a similar but separate part of the Level I screening process and has the responsibility of approving admissions to nursing facilities for individuals identified as having a MI or ID. Prior to 1987, several court cases were filed against Wisconsin that demonstrated inter-agency issues for providing community supports in the most integrated setting for individuals with MI or ID. The court cases were resolved by state statute mandating that the PASRR county liaison must approve the *County Review of Nursing Home, IMD or ICF/ID Referrals Form F-20822* to admit a person who has MI or ID to a nursing facility; this form can be electronically filled out but not electronically submitted. The designated county PASRR liaison is responsible for completing the F-20822 form.

Wisconsin saw substantial benefits of linking the F-20822 form with the PASRR process because of the significant role between counties, the nursing facilities and the PASRR contractor. In Wisconsin ADRCs provide information and assistance for individuals in applying for benefits regarding long term care, Medicaid, Social Security and other federally

qualified benefits. A county PASRR liaison, who may be staffed with an ADRC, completes the F-20822 form which goes back to the nursing facility. Then, the Level I form goes to the PASRR liaison for possible Level II evaluation. To ensure buy-in from nursing facilities, state statute §46.283 requires all nursing facilities to contact the ADRCs when the individual seeking admission is: 65 and older; or has a MI, ID, or RC and that condition is expected to continue for at least 90 days.

The state found that applicants were quickly identified and referred based on this collaborative county-level process. The checks and balances between PASRR, ADRCs, and nursing facilities has helped the state work together in providing a more seamless screening and referral system to ensure individuals are being empowered to make informed community living choices. For example, state statute §46.283 has helped the state strive toward transitioning residents who desire community living. A 2011 Status Report of Wisconsin's ADRCs found that over a twelve-month period, 5,791 nursing facility residents were referred to a local ADRC to explore community relocation. Of those, 774 were connected to services through their local ADRC and transitioned back into their community.³

Recommendations

Better coordination between states' PASRR processes and a state's broader access system to LTSS would better serve older adults and individuals with disabilities who have behavioral health, physical health, and community living needs who require LTSS.

The following recommendations are first steps to work towards building those relationships and reducing or eradicating the silos:

- States seeking to expand linkages between PASRR and a state's NWD System should look to the Federal guidance found in the State Medicaid Director (SMD) letters 16-004⁴, 16-009⁵, and 16-010⁶ in order to explore the requirements for leveraging the enhanced 90/10 federal medical assistance percentage (FMAP).
- Develop a cross-systems training practice for staff throughout a state's NWD System and PASRR staff to learn and understand each other's role and system process. Cross training topics should include information about systems of care and resources as well as clinical issues. As an example, training local ADRC on Mental Health First Aid Older Adults curriculum in order to better understand the needs of older adults with mental health conditions.

³ 2011 Status Report: Aging and Disability Resource Centers of Wisconsin. January 2012.

https://www.dhs.wisconsin.gov/publications/p0/p00251_2011.pdf

⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16004.pdf>

⁵ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16009.pdf>

⁶ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16010.pdf>

- Explore opportunities of collaboration with nursing facilities through training. Topics to explore include training local ADRC staff to request the PASRR evaluation when they receive a call from nursing facilities, and developing a notification system for nursing facilities to release the PASRR evaluation to the ADRC staff.
- States should continue the development of secure web-based PASRR systems nationwide, with a future focus of linking with their NWD System either through a web-based IT structure or through direct relationships by building/strengthening the linkage in their processes.

Conclusion

With a national effort for states to rebalance their Medicaid LTSS systems, some states are making strides by improving the efficiency of their PASRR systems through the use of a secure web-based or electronic system and by developing a timely linkage between the PASRR and their broader access systems to LTSS. A few states—Indiana, Utah and Wisconsin—have demonstrated the ability to work with government partners, community providers, and stakeholders to improve the efficiency of their PASRR processes. These states are engaged in creating direct relationships with the ADRC networks, enhancing linkages to the person-centered counseling model, and building efficient and high quality referral processes. The development of relationships and communication between PASRR programs and ADRCs has the potential to: shorten hospital stays; divert individuals from institutional nursing facility stays; and shorten nursing facility stays with an increased focus on return to a lower level of care whenever possible, that results in a more person-centered process for older adults and individuals with disabilities. The national rebalancing effort to shift from institutional care to community living must continue to thrive in order to ultimately achieve the vision that the creators of both the PASRR and OAA legislation were hoping to achieve, which is for individuals to live, learn, recreate, recover, and thrive in the most integrated setting appropriate to their needs and choices.