

Nursing Facility and Large ICF-IID Overarching Plan Draft
Department of Behavioral Health and Developmental Services
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Background

The history of the treatment of individuals with intellectual and developmental disabilities has been a rollercoaster of extremes. From the time of the first American colonists, people with disabilities were seen as a physical and financial burden, resulting in settlement laws that excluded them from community. In the mid 1800's, children and adults once housed in asylums and almshouses had early advocates who sought to educate and improve the conditions of their lives through community integration; only a few years later these efforts lost traction.¹ The increased industrialization and urbanization in the United States diluted successful efforts. States and territories created programs for people with specific disabilities housed in large institutions. The growth of these residential facilities for the “feeble minded” and “developmentally disabled” (whose needs exceeded the abilities or desires for their families to care for them) led to sending children and adults with IDD off to spend their lives in the large institutions still operating today.

Experiments to weed out and prevent these conditions from burdening society were explored by experts, spawning the eugenics movement and subsequent horrific crimes of euthanasia and sterilization, reinforcing negative societal beliefs, and blaming individuals with intellectual and developmental disabilities (IDD) for the spread of crime and disease. It was not until the 1950's that advocates in the form of private organizations such as National Association of Parents and Friends of Mentally Retarded Children (now The Arc) sought and began to change attitudes and services for individuals with intellectual and developmental disabilities.²

In the 1960's, significant growth in community supports followed the legislative efforts of President Kennedy to raise awareness and education of individuals with intellectual and developmental disabilities. However, it would be nearly 30 years before state directed deinstitutionalization and focused efforts toward community integration would begin in earnest. Issues of funding and a lack of community-based resources continue, slowing access to supports that would afford people with IDD lives that are as similar as possible to those of mainstream society.³ At the same time, per person costs within institutions have increased, as large facility residence has declined. Thus, as Virginia works to ensure that all persons with IDD are afforded maximal person-centered independence, we must be mindful of the findings of historical research:

Transitioning people with IDD from institutional settings to community settings requires attention to many things, including appropriate housing and co-residence selection, negotiation of staff needs with service users' needs, organizing a culture of engagement in the home and in the community, and focus on quality of life.⁴

Deinstitutionalization for large groups based on similar motivations, “severe mental illness should be treated in the least restrictive setting,”⁵ has in part, been attributed to the national mental health crisis we face today. Between 1955 to 1994 state-based psychiatric hospital closures nationwide, placed known severely mentally ill individuals in communities without ensuring

that they had the medications and rehabilitation services that allowed them to be successful, and prevented facility re-entry while in crisis. Ultimately this action has afforded the majority population the ability to live a quality community based life; yet, a significant minority has been left disenfranchised, homeless, and underserved.⁶

We are at a precipice in Virginia, where, if we are to avoid “*déjà vu all over again*,”⁷ we must proceed with caution. As important as it is to ensure that people with IDD are integrated into their communities and afforded opportunity to maximize the quality of their lives, we must do so in such a way that we prevent unintended consequences. Specifically, Virginia is taking care to ensure that supports are firmly pre-arranged, while safeguarding resources of dependable shelter, medication, assistance with ADLs, and engagement activities by their current residence. This is demonstrated by the discharge process model developed for the training centers and implemented over the last two years.

Introduction

In March 2014, the Department for Behavioral Health and Developmental Services (DBHDS) drafted the *Implementation Plan for Increasing Community Options That Support Children and Adults with Intellectual and Developmental Disabilities With High Medical Needs in Integrated Settings, (Initial Plan)*, in response to the Independent Reviewers recommendations in Report #3, 2013.

*Independent Reviewer’s Recommendation (Report # 3 – April 7, 2013 –October 6, 2013): Complete an implementation plan by March 31, 2014 that includes measurable mid- and long-term goals that reflect the desired outcomes for individuals with ID/DD (living in nursing homes and large ICF-IID/IDDs). The plan should identify implementation milestones to achieve for each goal, the person responsible, the resources needed, and an ongoing evaluation process. The plan should identify how long term success will be measured, and the means and methods by which data will be gathered to evaluate its progress.*⁸

The *Initial Plan*, highlighted data specific to how other states utilized resources to close NFs and ICF-IIDs as reported in *State of the States in Developmental Disabilities, 2013*.⁹ In comparing the states, the authors of the *Initial Plan* highlighted Oregon’s successful utilization of a Home and Community Based Waiver and temporary respite in nursing facilities while locating and coordinating community supports. They also noted that while overall costs for the program were lower than Virginia, their waiver support fund allocation was higher. They noted that a State Plan Amendment would be needed such that Federal-matching funds would be available to Virginia residents with IDD (so that funding for specialized services currently provided through the Omnibus Budget Reconciliation Act of 1987 (OBRA) could be expanded). The *Initial Plan* also identified the need to relook at the Preadmission Screening and Resident Review (PASRR) process, the need for waiver redesign and the need to maximize waiver funds allocated via different programs to subsidize community based cost. The current waivers identified included:

- ID Waiver -provides home and community-based services to individuals under six (6) years of age who are “at developmental risk,” and to individuals six (6) years of age and older who have a diagnosis of intellectual disability and who: (1) Qualify for institutional care in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IID); (2) Are at imminent risk of ICF-IID placement, and (3) Need home and community-based services to live in the community rather than living in an ICF-IID, and meet financial eligibility criteria.¹⁰
- DD Waiver -provides services to individuals who are 6 years of age and older who have a related condition and do not have a diagnosis of Intellectual Disability who (1) meet the Intermediate Care Facility for Individuals with Intellectual Disabilities or Persons with related conditions (ICF-IID) level of care criteria (2) are determined to be at imminent risk of ICF-IID placement, and (3) are determined that community-based care services under the DD Waiver are the critical services that enable the individual to remain at home rather than being placed in an ICF-IID.¹¹
- Technology Assisted (Tech) Waiver -provides home and community-based services for individuals who depend on technological medical support to survive, need substantial, ongoing skilled nursing care, and would otherwise have to live in a hospital, nursing home, or other institution.¹²
- EDCD Waiver -provides services that help individuals live in their own home or community instead of a nursing home. It is available to individuals 65 years of age and older, and to individuals of any age who have a disability. Individuals who depend on another person for their supports and have medical or nursing needs may be eligible for the EDCD waiver.¹³
- EPSDT -is a comprehensive and preventive healthcare program for children under the age of 21 who receive Medicaid. EPSDT provides medical, hearing, vision and dental checkups. EPSDT coverage includes: Hearing Aids, assistive technology, personal care, private duty nursing medical Formula and medical Nutritional supplements, physical, occupational, behavioral, or speech therapies, one-to-one aides, ABA therapy.¹⁴

Subsequent to posting the *Initial Plan*, representatives of The Arc of Virginia (The Arc of VA) and the Virginia Board for People with Disabilities (VBPD) provided written public commentary. Their comments stated that there was a lack of clarity and specificity to the *Initial Plan* draft, and that it did not reflect the comprehensive and operational detail they expected. The purpose of this paper is to revise the proposed plan for identifying, transitioning, and integrating children and adults with intellectual and developmental disabilities from nursing facilities and large intermediate care facilities, into their communities, and diverting at-risk children and adults from entering nursing facilities and intermediate care centers.

Two strategies will need to be employed simultaneously: “*Closing, but not locking, the front door,*” by changing the existing Preadmission Screening and Resident Review (PASRR) process, to work more effectively with the Hospitals, the Health Department (VDH), the Department of

Social Services (VDSS), and Community Service Boards (CSBs), while partnering with DBHDS Community Resource Consultants (CRCs), Community Integration Managers (CIMs) and other stakeholders to identify and arrange community supports, that would result in diversion, minimizing or eliminating the need for further placement (because of an IDD diagnosis). In addition, DHDBS will need to work with stakeholders to avoid opening new large ICFs for individuals with IDD through education of providers and encouraging the consideration of state policy changes that would better support community integration. The second strategy, “*Exiting out the back,*” is an effort to transition residents into the community. This can only happen by partnering with CSBs, CIMs, CRCs, private providers and other stakeholders to locate and secure resources for residential living, and connecting with the Developmental Disabilities Health Support Network (DDHSN) to afford institutionalized residents the opportunity to succeed within their preferred community while receiving individualized and appropriate healthcare services.

Exit Strategies

Assessment

Establishing goals toward this end is data driven. Assessments must be done from a broad perspective, looking at the state in toto to determine a regional starting point. Assessments must also be done individually, to evaluate the circumstances from which they arrived and to decide what resources are needed for success in the community. To date, these data have neither been collected nor considered in such a way as to assess the implications for the process.

A comprehensive assessment of the state and regional placement of people with IDD is the first overarching goal of this plan. The data must identify in relative “real-time” the resident, age, IDD related diagnosis, institutionalization /medical diagnosis, the facility name, location (both county and region), and the dates of the last service for the purposes of effective planning. To date, this data has been difficult to obtain. In part this might be best understood by describing “who does what?”

- Nursing facilities are state licensed and federally certified by the Office of Licensing and Certification/Virginia Department of Health (OLC/VDH). The majority of Virginia’s nursing facilities accept Medicare/Medicaid reimbursement. The SNF designation indicates Skilled Nursing Facility beds eligible for Medicare reimbursement. The NF designation indicates nursing facility beds eligible for Medicaid reimbursement. A nursing facility’s inspection reports are available at the facility or by contacting OLC/VDH.
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) are community-based homes (institutions) licensed by DBHDS and federally certified NF only by OLC/VDH.¹⁵
- Reimbursement for long-term care, service authorization, and program integrity reviews are performed by Department of Medical Assistance Services (DMAS) and their contract agencies. DMAS also oversees contracts with Virginia Department of Social Services

(VDSS), VDH, acute care hospitals, and other screening entities to conduct pre-admission screening (PASRR) for services.¹⁶

- DBHDS, is responsible for coordination of mental health, developmental disabilities, and substance abuse services through the local CSBs and private providers, and is responsible for the day-to-day operations of the ID and DD Waiver and the Day Support (DS) Waiver. DBHDS also administers the PASRR Level II screening, which is a Federal requirement for nursing facility placement.
- The Department for Aging and Rehabilitative Services (DARS) offers consumer-directed home care services through the Personal Assistance Services (PAS) Program and Brain Injury PAS. Individuals must have physical and/or sensory disabilities to qualify.¹⁷
- Virginia Health Information (VHI) provides consumers with information about NFs and ICF-IIDs (along with other healthcare agencies) related to their quality and performance measures in an effort to ensure informed choice.¹⁸

As demonstrated by the list of state agencies involved in direct and indirect services for institutionalized individuals residing in Virginia's NFs and ICF-IIDs, the ability to attain real time and accurate data is daunting without the technology infrastructure to cross-reference information. This infrastructure currently does not exist, however DBHDS is working to upgrade its data capabilities, some of which may provide improved access to these important statistics. An example of current data available for determining state census for individuals with IDD in NFs and ICF-IIDs was obtained from DMAS, and dated January 28, 2014. It reflects Medicaid billing for institutionalized children between March 1, 2012 and December 2013, (a subsection of the target population). At that time, there were 265 children under the age of 23 from twenty nursing facilities and large intermediate care facilities. Their regions and locations are listed below.

Region I (Total=2)

- 1 at Harrisonburg Health & Rehab Center-Rockingham County
- 1 at Virginia Baptist Hospital-Lynchburg

Region II (Total=41)

- 1 at Woodbine Rehab Health Center, LLC-Alexandria
- 35 at ILIFF Nursing & Rehab Center-Dunn Loring- Fairfax County
- 2 at Community Residences, Inc.-CRI Oak St. ICF-Manassass- Prince William County
- 2 at CRI Lake Jackson Drive ICF- Manassass- Prince William County
- 1 at CRI-Parliament ICF-Springfield-Fairfax County

Region III (Total=7)

- 1 at Golden Living Center-Blue Ridge-Galax
- 1 at Ridgcrest Manor Nursing Home-Duffield-Scott County
- 1 at Cumberland Mountain Community Services-Cedar Bluff- Tazewell County
- 3 at Brian Center Nursing Care/FINC- Fincastle - Botetourt County
- 1 at Chatham Health and Rehabilitation Center- Pittsylvania County

Region IV (Total=61)

61 at Children's Hospital-Richmond

Region V (Total=151)

37 at Holiday House- Portsmouth

1 at Sentara Nursing Center-Portsmouth

1 at Sentara Nursing Center VA Beach

109 at St Mary's Infant Home-Norfolk

1 at Sentara Center-Norfolk

1 at Envoy of Williamsburg, LLC

1 at City of Virginia Beach West Neck Residence¹⁹

The regional data provided here is referential only; however, further inspection of the data reveals a significant number of residents without recent billing (90 days prior to December 1, 2013). Thus, it appears that these children have exited the institutional setting. The remaining children twenty-two and younger total: 84 at St Mary's Infant Home, 22 at ILIFF Nursing & Rehab Center, 27 at Holiday House, 43 at Children's Hospital, 1 at Brian's, Center, 2 at CRI Lake Jackson Drive ICF, 1 at CRI Parliament ICF, 1 at Cumberland Mountain, 1 at Harrisonburg, and 1 at CRI Oak Street; the cumulative total is **183**.²⁰ Because of the time lapse (represented by billing submission dates) and no other means of accurate statewide reporting to date, this data will need to be confirmed by comparing it to the next available billing data report.

As a result of the insight obtained from this data analysis, DBHDS will work with DMAS to establish an accurate and timely reflection of residential placement related to billing. However, it is clear, that billing data is not the optimal source for identifying residence. Unlike Training Centers (TCs), nursing and large intermediate care facilities are public and private agencies and not compelled to accommodate the State's objectives regarding community diversion and transition. Though they may be compelled in some cases to allow facility access for the purpose of conducting individual assessments, they are not obligated to ensure patient residency while investigating community-based resources in an effort to discharge the resident to the community. It is a delicate mission and has a potential for unintended consequence.

Information that can also be utilized for the purposes of prioritization (because it may infer facility-based quality issues) includes the federally mandated clinical assessment called the Minimum Data Set (MDS). This is done for all residents quarterly and for changes in condition. Another tool is the Online Survey, Certification and Reporting (OSCAR). This is mandated by the Centers for Medicare & Medicaid Services (CMS), and identifies the nursing home operational characteristics and aggregate patient health deficiencies issued during the three most recent state inspections and recent complaint investigations.²¹ The MDS data are updated quarterly, OSCAR data are updated monthly by VHI. However, even here there is a lag time in reporting and no enforced mandate for reporting- thus its usefulness remains, unclear. Ultimately, it may be that there is need for regulation or policy changes to support more accurate and accessible reporting data.

In addition to aggregate data, the information must be individualized and comprehensive. An initial review of the MDS performed by the PASRR nurse can guide the need for enhanced

assessment. Historical and real time data need to be reviewed and re-evaluated to determine if family placement is an option, and if not why? Support needs to account for the physical, mental, and social needs of the individual as well as the needs of the family and the funding sources available to prevent future system failure. If family placement is not a possibility, is sponsored living an option? Are there barriers to sponsored living that might be able to be addressed with small policy or regulation changes? Are there other barriers that could be removed with minor changes in process that would not compromise the health and safety of the individual with IDD? For children with high medical needs, a face- to- face assessment for the purposes of long-range planning may need to be done by the PASRR nurse, or if regionally available, a community based registered nurse (RN).

Planning

Successful community integration is reliant on successful planning. Planning for the purposes of this paper was initiated by the evaluation of the PASRR process and the recognition of its need for revision and clarity. According to the DBHDS' PASRR contract manager, historical data for the state of Virginia yields an 88% acute care hospital referral source. Specifically this means that the PASSR I screening for admission to a NF has been initiated and completed by community-based acute care hospitals. The completion of this screening in effect, requests NF placement and triggers PASRR II completion by the contracted agency, Ascend, paid for by the state of Virginia through DMAS, if the individual assessment indicates intellectual disability (ID), developmental disabilities (DD,) mental illness (MI), or related conditions (RC). The remaining 12% of referrals who have completed the PASRR I screening recommending NF placement originate from VDH and VDSS. In the months preceding the *Initial Plan* of March 2014, a team of stakeholders worked with professional consultants from the PASRR Technical Assistance Center (PTAC). The outcome of this consultation is graphically depicted in Appendix I.

While the graphic does not specify the tasks associated with roles or current barriers to successful implementation. It does provide a clear linear description of an optimized workflow. It also offers, a means for visualizing points where intervention might occur to ensure that the least restrictive, most supportive environments might be considered as an alternative to NF placement, resulting in diversion rather than placement. Additionally it is clear, that while NF placement may have been a permanent residential environment for individuals in the past, it is no longer. There is not a stop sign after the facility (depicted as 4b), but an arrow toward funding and transition, indicating periodic review, and evaluation toward community placement. Other more global recommendations included identifying and formalizing written guidelines for PASRR process and tracking of data, ensuring that all NF residents with IDD and related conditions had PASSR II screens that were current and in compliance with federal regulations, that PASRR information was accurate and current, that individuals were properly screened irrespective of payment source, and to develop written guidance/education materials to ensure that the public and referring facilities understand the mission goals and values of person-centered, individualized planning. The graphic depiction of the PASRR process in Appendix I, and the identified recommendations, served to guide the goals and objectives described within the context of this plan.

Implementation/ Discharge Process

A literature review reveals a lack of data to support routine or best practices for prioritizing the transition/discharge of children and adults from institutionalized care. Along with a schedule to organize a departmental effort for transitioning children, prioritization criteria may need to be devised and considered to ensure that every opportunity available is seized in a timely manner. Based on the data provided by the statewide, regional, and person-centered assessments, a schedule matching resource availability with regional volume, and dependent on the individuals' and community resources, it may make sense to prioritize in such a way that (like the TC's) region by region, institutionalization can be eradicated or substantially reduced. For example, if facility residents are amenable, and Region I and Region III, (currently with a low institutionalization volume) can support community integration, these regions might be targeted for priority community placement. If however, there are no, or low regional supports within these communities, better prepared communities may be selected for the first region-based transition.

Additional agency prioritization criteria recommendations include:

1. Children under twenty-two where the primary diagnosis is an IDD identified diagnosis and the individual, parent/guardian /AR is agreeable to discharge.
2. Children who having willing community based parent/guardian / AR if adequate community based supports were put in place.
3. Facility selection urgency related to MDS and OSCAR information.
4. Region based priority due to high resource availability (until all region-based efforts executed to fullest extent for children under twenty-two).
5. Adults where the primary diagnosis is an IDD identified diagnosis and an individual and/or guardian/ AR is agreeable to discharge.
6. Adults who having willing community based family and/or guardian/ ARs with adequate community based supports.
7. Region based priority due to high resource availability until all region-based efforts executed to fullest extent for adults 23 or older.

Once the residents targeted for discharge have been identified in regional facilities, the discharge will follow the process established for discharging residents of the Training Centers (with a modified individually appropriate timeline). Discharges will be implemented in coordination with the Director of Training Center Discharges, Community Integration Managers, and PASRR nurse in conjunction with community providers. The *Virginia's Training Center to Community Move Process* has been extremely successful within the state to date, and while this has been a twelve-week process, consideration for those with complex medical, behavioral, and social situations may necessitate variations. (See Appendix II)

Therefore, a pilot initiative is recommended such that a targeted Region for discharging children into the community include the planning, prioritization, and process consistent with the established State-based discharge plan, (with modifications as needed and appropriate) be

initiated and revised as needed at 3-month intervals until the process validity and reliability is well established. If effective it will be duplicated in other institutions and other regions based on the criteria stated above. The timeline will depend on the evaluation results and feedback from participating stakeholders.

Implementation/Diversion Strategies

Successful outcomes for diverting individuals from entry into nursing facilities are largely dependent on revising the current PASSR process and creating an effective Health Supports structure rich in expertise and depth. The specifics of DDHSN are available in the *Developmental Disabilities Health Support Network Overarching Plan Draft*.

As outlined in the *Initial Plan* draft, the PASRR process to date has been ineffective. Several stakeholder meetings prior to the initial report identified a lack of training, and a lack of effective process implementation. Subsequent meetings with individual stakeholders and an additional literature review have elicited additional barriers and supports to be addressed. It should be noted that problems with the PASRR process are not unique to the Commonwealth, or for screening people with intellectual and developmental disabilities. There are overarching issues recognized by the US Department of Health and Human Services (USDHHS) that if addressed will aid the state to strengthen tool utilization. Examples include:

1. Clarifying the purpose of the PASRR at the organizational level.
2. Increase CMS oversight to reduce facility non-compliance.
3. Increase efforts to communication with third party agencies and referral organizations.
4. Partner with other state based agencies to ensure PASRR mission prioritization.
5. Educate nursing facilities and referral agencies regularly and as needed.
6. Increase fiscal resources to operationalize the above recommendations.
7. Improve Medicaid billing process, rules and technology.²²

Specific Operational Challenges

- Hire a PASRR nurse: It is important to hire the right person for this position. Interviews have been ongoing, but unsuccessful to date. The job posting has been written and reposted at new venues.
- Establish the beginning infrastructure of the DDHSN to support the health needs of individuals with IDD in the community.
- Redesign the waiver supports to provide adequate funding for residential, day, and health needs.
- Develop a regional and statewide resource list identifying community supports to include residential and day providers, health professional providers, and transportation providers.
- Create and establish educational programs for residential, family and day providers.
- Create, and develop educational programs for and in partnership with community and academic health professional related to the needs of individuals with IDD.
- Develop state and provider partnerships to innovate in the areas of technologies and service provision to maximize and improve current resources.

- Develop policies to support the overarching mission and goals of the efforts to ensure that individuals with IDD live in the least restrictive environments possible.
- Support advocacy groups in their efforts to improve the lives of individual with IDD by acting as good stewards of the resources provided in the form of Waiver supports.

Conclusion

The future is bright for the children with IDD placed in nursing and large intermediate care facilities. Extraordinary efforts have begun to ensure that they are able to return to their communities within safe and supportive environments. Though it may take longer than some would wish, it is important to remember that this process must be done well. Excellence is often crafted in the details. As we move toward realizing the goals of this plan, stakeholder involvement to operationalize these details will be critical. The movement however has begun, and there is no turning back.

Summary of Goals and Objectives

I. Develop an effective data collection infrastructure to support community integration for individuals with intellectual and developmental disabilities.

- Establish an accurate reporting system for identifying ICF-IID and NF residents with IDD.
 - Partner with DMAS and VHI to determine an accurate reporting system.
 - Partner with interagency Information Technology (IT) personnel to establish a dashboard/ accessible reporting system.
 - Identify the need for regulation or policy changes as indicated.
- Identify the individual needs particularly as related to persons who are medically fragile or have high medical needs.
 - Partner with regional CSB RNs to identify the clinical needs within institutions for children with IDD.
 - Organize the data by facility and region to assist with prioritizing and developing long-range transition plan.
- Identify the specific individual histories that would provide insight into the barriers felt by families to home returns.
 - Partner with individuals, families/ARs, intra-agency departments, CSBs, private providers, and advocacy representatives to understand the needs and supports needed.
 - Identify and establish partnerships with health professionals to meet the health support needs toward successful community integration.

II. Ensure community-based sustainability for individuals with intellectual and developmental disabilities.

- Identify the region-based resources available to provide person centered supports.
 - Partner with intra-agency departments, CSBs, private providers, parents, advocacy representatives and ARs to prioritize and focus transition plan.
- Identify the region-based resources available to provide health-related supports for the purposes of planning for future NF/ICF-IID diversion of children and adults with IDD.
 - Partner with intra-agency departments, CSBs, private providers, parents, advocacy representatives and ARs to establish and organize a health resource list.
- Seek to ensure safe care intensive environments such as family and/or sponsored living arrangements for the medically fragile.
 - Partner with intra-agency departments, CSBs, private providers, individuals, parents, advocacy representatives and ARs to explore alternatives to group homes or environments with multiple medically fragile individuals.
 - Utilize the DDHSN to ensure health support coordination.
- Children and adults remain in their communities receiving appropriate supports.
 - Establish DBHDS policies that outline the expectation of exhausting community options prior to NF and ICF-IID placement consideration.
 - Establish policies that require monthly justification by NFs, ICF-IID, and CSBs for all children and adults who must reside within an institutional environment.
 - Establish policies that define appropriate release from DBHDS oversight of individuals with IDD. (For example, within NFs due to age and chronic progressive complex illness, or extreme medical necessity related to a progressively declining medical condition that is unrelated to IDD specific diagnoses.)
 - Consistent with the April 2014 *Virginia Department of Behavioral Health and Developmental Services Enhanced Case Management Criteria Instructions and Guidance*, establish policies to follow existing algorithm for Enhanced Case Management (ECM) and intervals for re-evaluation.
- Reduce the development of large ICF-IIDs in Virginia.
 - Partner with VDH to bar certification and licensure of new large ICF-IIDs.
 - Work with stakeholders to establish/develop alternative residential options.

III. Create an effective process for diversion and transition such that individuals with intellectual and developmental disabilities reside in the least restrictive environments.

- Determine if a schedule for discharging residents from regions based on needs and resources is realistic related to individual/community barriers.
 - Partner with intra-agency departments, CSBs, private providers, individuals, parents, advocacy representatives and ARs to create a discharge schedule.

- Discharge children ages twenty-two and younger who have been placed in nursing facilities and large intermediate care facilities, who are residents due to their IDD related diagnoses.
 - Partner with CIMs and CSBs to ensure safe and thorough consideration and coordination of care to discharge residents to community based settings.
- Discharge adults who have been placed in nursing facilities and intermediate care facilities, who are residents due to their IDD related diagnoses, and do not need to remain within the facility due to end-stage and other chronic progressive illnesses.
 - Partner with RNCCs, VDSS, CIMs and CSBs to ensure safe and thorough consideration and coordination of care to discharge residents to community based settings.
- Revise the current PASSR Process. (See Appendix I)
 - Establish a clear and written mission statement for the PASRR process at DBHDS.
 - Partner with DMAS and the Department of Health (VDH) to strengthen oversight and communication with nursing facilities.
 - Develop and implement a community agency education curriculum to ensure appropriate PASRR I referral.
 - Establish a specific contract with third party PASRR agencies (such as ASCEND- an independent federal assistance contractor) that addresses the mission of the DBHDS.
 - Ensure that there is contract-based language to ensure diversion alternatives to NF placement are pursued following the comprehensive needs evaluation.
 - Pilot categorical Level II decisions (allowed by federal law- providing temporary approval for NF admission to some persons with a suspected PASRR condition) and provide respite for up to 90 days while engaging the DDHSN resource coordinators –RNCCs, CIMS, and CSBs.
 - Develop policies to support prompt PASRR II evaluations and reviews.
 - Contract that the full PASRR II review is completed within 72 hours and submitted to the state PASRR nurse.
 - Ensure that professional evaluations and person-centered recommendations include all service needs of the individual to be reflected in the Level II PASRR evaluation summary report.

IV. Organize a broad based educational initiative to promote understanding of person-centered planning for individuals with intellectual and developmental disabilities at risk for NF or large ICF-IID placement.

- Develop educational programs to promote understanding of community resource support options.
 - Partner with local hospital case management programs to recognize individuals with intellectual and developmental disabilities and the need for the least restrictive environment.

- Collaborate with community-based IDD case managers to facilitate greater awareness of acute care hospital discharge-planner's learning needs to divert individuals with intellectual and developmental disabilities from NF placement.
- Identify resources available to CSBs, acute care hospitals and representatives of VDH and VDSS related to the Health Supports Network.

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References

- ¹Beirne-Smith M, Patton JR, Kim SH. 2006. *Mental Retardation: An Introduction to Intellectual Disabilities. 7th edition.* Upper Saddle River (NJ): Pearson Merrill Prentice Hall.
- ² Beadle-Brown J, Mansell J, Kozma A. 2007. Deinstitutionalization in intellectual disabilities. *Current Opinion in Psychiatry* 20:437-442.
- ³ Beadle-Brown J, Mansell J, Kozma A. 2007. Deinstitutionalization in intellectual disabilities. *Current Opinion in Psychiatry* 20:437-442.
- ⁴Harbour, C. and Maulik, P., (2014). History of intellectual disability. *International Encyclopedia of Rehabilitation*. Retrieved from <http://cirrie.buffalo.edu/encyclopedia/en/article/143/>
- ⁵Torrey, E.F. (1997). *Out of the Shadows: Confronting America's Mental Illness Crisis*. John Wiley & Sons, New York, 1997.
- ⁶Frontline. (2005, May 10) *The New Asylum*. Retrieved from <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html>
- ⁷ Yogi Berra. (n.d.). Personal quotation. Retrieved from <http://rinkworks.com/said/yogiberra.shtml>
- ⁸ Department for Behavioral Health and Developmental Services (DBHDS) drafted the *Implementation Plan for Increasing Community Options That Support Children and Adults with Intellectual and Developmental Disabilities With High Medical Needs in Integrated Settings*
- ⁹ University of Colorado Department of Psychiatry (2013). The State of the States in Developmental Disabilities. Retrieved from <http://www.stateofthestates.org/>
- ¹⁰ Virginia Easy Access. (n.d.). Intellectual Disabilities (ID) Waiver Virginia.GOV. Retrieved from <http://easyaccess.virginia.gov/waiver-mrid.shtml>
- ¹¹ Virginia Easy Access. (n.d.). Individual and Family Developmental Disabilities Support (IFDDS) Waiver. Virginia.GOV. Retrieved from <http://easyaccess.virginia.gov/waiver-ifdds.shtml>
- ¹² Virginia Easy Access. (n.d.). Technology Assisted (Tech) Waiver. Virginia.GOV. Retrieved from <http://www.easyaccess.virginia.gov/waiver-tech.shtml>
- ¹³ Virginia Easy Access. (n.d.). Elderly or Disabled with Consumer Direction (EDCD) Waiver Virginia.GOV. Retrieved from <http://www.easyaccess.virginia.gov/waiver-consumerdirection.shtml>
- ¹⁴ Commonwealth Autism Service. (2013). Early Periodic Screening Diagnosis and Treatment (EPSTD). Retrieved from <http://www.autismva.org/resources/epsdt>

¹⁵ Virginia Department of Health. (2013, July). *Facilities Directory*. Retrieved from <http://www.vdh.virginia.gov/OLC/Facilities/>

¹⁶ Department of Medical Assistance Services (2011, December) General information. Provider Manual. Retrieved from <https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/>

¹⁷ Department of Medical Assistance Services: Long-Term Care Division. (2013, July). A guide to long-term care services in VA. Retrieved from http://www.dmas.virginia.gov/Content_atchs/ltc/ltc-guide_srvcs.pdf

¹⁸ Virginia Health Information. (2014). Long term care: Nursing facilities. Retrieved from http://www.vhi.org/nursing_region.asp?region=

¹⁹ Department of Behavioral Health and Development Services (DBHDS). (2014). NF_RECIP_LIST_SFY1. Internal Report. June 2014.

²⁰ Department of Behavioral Health and Development Services (DBHDS). (2014). NF_RECIP_LIST_SFY1. Internal Report. June 2014.

²¹ <https://www.medicare.gov/nursinghomecompare/Data/Data-Sources.html>

²² Linkins, K., Lucca, A., Housman, M., and Smith, S. (2006). PASRR Screening for Mental Illness in Nursing Facility Applicants and Residents. *US Department of Health and Human Services* pgs. 39-41 Retrieved from <http://store.samhsa.gov/shin/content/SMA05-4039/SMA05-4039.pdf>

APPENDIX II

Discharge Process Outline

- I. Initial Pre-move Meeting
 - a. All stakeholders involved in the individual's life now/future
 - b. Needs/wants, essential supports
 - c. Brainstorming for community alternatives
- II. Individual/AR/CSB review of community residential providers
 - a. Partner with CSBs, private providers and RN Care Consultants (RNCCs) –working with family/AR to find providers. (For more information on RN Care Consultants, refer to the *DDHSN Overarching Plan Draft*).
- III. Provider Tours
 - a. Individual/family evaluation of residential and employment/day providers
- IV. Provider Information Requests
 - a. Licensing review (OL)- if needed
 - b. Human rights review (OHR)- if needed
 - c. CRCs
- V. Provider Pre-Move Meeting
 - a. Provider is selected
 - b. Meet with provider/individual and all relevant stakeholders
- VI. Day Visits
 - a. Individual goes to day and residential providers (4+hours)
- VII. Evening Visits
 - a. Individual visits residential provider
- VIII. Provider Training and Overnight Visits
 - a. Residential provider brought to NF and trained-general-if allowed
 - b. Specific residential essential support needs training
 - c. Resident stays overnight 2 or more nights (if tolerated)
- IX. Final Pre-Move Meeting
- X. Preparation for Moving
- XI. Moving
- XII. Post-Move Monitoring
 - a. Site visit by RNCC, CIM, CSB within 7 days
 - b. Site visit by RNCC, CSB and within 1 month
 - c. Site visit RNCC, CRC at 2 months and OL and OHR as needed
 - d. Site visit by RNCC, and CSB monthly for minimum of 1 year

APPENDIX III

Acronyms	
Abbreviations	Name
Arc	Arc of Virginia
ARs	Authorized Representatives
CIMs	Community Integration Managers
CMS	Centers for Medicare & Medicaid Services
CRCs	Community Resource Consultants
CSBs	Community Service Boards
DS	Day Support
DARS	Department of Aging and Rehabilitative Services
DBHDS	Department for Behavioral Health and Developmental Services
DMAS	Department of Medical Assistance Services
DDHSN	Developmental Disabilities Health Support Network
EDCD Waiver	Elderly or Disabled with Consumer Direction Waiver
EPSDT Waiver	Early Periodic Screening Diagnosis and Treatment Waiver
IFDDS Waiver	Individual and Family Developmental Disabilities Support Waiver
IT	Information Technology
IDD	Intellectual and Developmental disabilities
ICF	Intermediate Care Facility
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disability
MDS	Minimum Data Set
NF	Nursing Facility
OBRA	Omnibus Budget Reconciliation Act
OLC	Office of Licensing and Certification
OHR	Office of Human Rights
OSCAR	Online Survey Certification and Reporting
PASRR	Preadmission Screening and Resident Review
PAS	Personal Assistance Services
RN	Registered nurse
RNCC	RN Care Consultants
TC	Training Centers
USDHHS	US Department of Health and Human Services
VBPD	Virginia Board for People with Disabilities
VDH	Virginia Department of Health
VDSS	Virginia Department of Social Services
VHI	Virginia Health Information