STATE OF CONNECTICUT
Department of Mental Health & Addiction Services
Commissioner's Policy Statement and Implementing Procedures

dmhas
A Healthcare Service Agency

SUBJECT:	Nursing Home Placement Policy
P & P NUMBER:	Chapter 6.16
APPROVED:	Miriam Delphin-Rittmon, Commissioner Date: 8/29/17
EFFECTIVE DATE:	11/1/1983
REVISED:	1/2017, 10/15/2015, 8/15/2011, replaced Commissioner's Policy Statement No. 14 dated November 1, 1983 November 1, 1983.
	Federal Register 42 CFR Part 441 (Medicaid Home and Community-based Settings) DMHAS Commissioner's Policy Statements: Chapter 6.14 Promoting a Recovery-Oriented Service System Chapter 6.25 Application for Involuntary Conservatorship of DMHAS Clients, Policy #33- Individualized Treatment
FORMS AND ATTACHMENTS:	The DMHAS Mental Health Waiver http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=425724 The DMHAS Nursing Home Diversion and Transition Program http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=423428

STATEMENT OF PURPOSE: The Nursing Home Placement Policy addresses two levels of involvement by the DMHAS service system with DMHAS clients (or 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.

POLICY:

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

a) DMHAS staff shall ensure that clients receive person centered planning when in skilled nursing facilities. The person centered planning process will inform discharge plans that include 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. DMHAS staff shall ensure that no person is admitted to any institution for long term care without consideration of less restrictive alternatives and available community resources to avoid such placement.

b) Clients, and conservators as appropriate, will receive adequate information from DMHAS staff regarding all community-based options, including waivers to make an informed choice for community services. The overall presumption is that permanent supportive housing is the

most integrated setting.

c) A nursing home may be considered the least restrictive, most integrated setting for a determined period of time if the following criteria are met:
   1. Client has physical, medical, and/or cognitive needs requiring 24-hour skilled nursing services (see nursing home level of care criteria below);
   2. The needs are documented in the client's record;
   3. 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
   4. The client's psychiatric symptoms/behaviors are stable and do not place the client or others at risk for injury.

d) 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. 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.

e) 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. Under PASRR, applicants to Medicaid-certified nursing homes must be screened to identify a diagnosis of serious mental illness (and/or developmental disability). 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.

f) 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 Nursing Home Diversion and Transition Program (NHDTP) Nurse Clinician may assist with this follow-up and monitoring process.

g) 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.

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

a) The DMHAS service system shall respond 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.

b) Nursing home clients transitioning to the community may require an appointment to establish

community mental health services. When possible this appointment should occur within the first week of the client's discharge from the nursing home. The NHDTP Nurse Clinician is available to assist with this process as necessary

c) Nursing home clients transitioning to the community may apply to the DMHAS-supported community housing programs. Housing staff responsible for the application process should 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.

d) For clients transitioning from the nursing home to the community, all community-based services and supports will be available to the client 120 days from the date the client chose the supports and services.

APPENDIX

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 activities of daily living (ADLs)* daily *plus* a Need Factor (see below).

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.

Activity of Daily Living (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 (physical therapy, occupational therapy, speech therapy, recreation therapy) and the individual is determined to have restorative potential.

b. Requires the presence 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.

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* **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.*