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Habilitation Coordination & Transition Planning

Preadmission Screening and Resident Review (PASRR)

Presentation Agenda

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- Habilitation Coordination Responsibilities
- Habilitation Service Plan (HSP) Development and the Habilitative Assessment
- Coordination of Specialized Services
- Bridging the relationship between the nursing facility and local intellectual and developmental disability authority (LIDDA)
- Community Living Options (CLO) Process
- Transition Planning

Habilitation Coordination

Assistance for a designated resident residing in a nursing facility to access appropriate specialized services necessary to achieve a quality of life and level of community participation acceptable to the designated resident and legally authorized representative (LAR) on the designated resident's behalf.

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Habilitation Coordinator's Responsibilities

- Develops the individual profile (IP) and habilitation service plan (HSP).
- Ensures specialized services (and/or generic services) are implemented on a timely basis.
- Conducts monthly contacts with person and (at least) every six months CLO discussions.
- Conducts ongoing monitoring.
- Convenes service planning team (SPT) meeting at least quarterly to monitor and revise the HSP.
- Notifies the relocation specialist if person desires to move to a community living option.
- Makes a referral to the LIDDA for assignment of the service coordinator (SC)/enhanced community coordinator (ECC) to assist with transition planning once the person chooses a program.

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Service Planning Team Meetings

A service planning team is a team convened by a LIDDA staff person that develops, reviews, and revises the HSP and the transition plan for a designated resident.

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Initial SPT Meeting

- SPT meets to review the PASRR Evaluation at the same time as the initial interdisciplinary team (IDT) meeting.
- SPT agrees upon recommended specialized services and assessments.
- SPT meets to develop the IP and HSP.
- CLO results are presented.
- SPT determines if any specialized services could help eliminate barriers identified in the CLO form and makes a plan, as needed.

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Quarterly and Special Update SPT Meetings

- Quarterly SPT Meetings are convened by the habilitation coordinator (HC) to review and revise the HSP and IP, as needed, at least quarterly.

- Special Update Meetings
  - Occur outside the quarterly timelines to address issues (such as significant changes with the person's medical condition and/or specialized services).
  - Do not reset the quarterly meeting due dates.

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Annual IDT/SPT Meeting

- Annual IDT Meetings are convened by the Nursing Facility. If the IDT agrees to the provision of habilitation coordination for a person, the habilitation coordinator convenes the annual SPT meeting immediately following the annual IDT meeting.
  - The habilitation coordinator is responsible for inviting all SPT members to the annual IDT/SPT meeting.
  - An annual IDT meeting is held for a person regardless of whether the person is receiving habilitation coordination or any other specialized service.
  - If the person has refused habilitation coordination, then there is no SPT for that person, but the HC still must attend the annual IDT meeting.

Note: Annual IDT/SPT meetings will reset the quarterly meeting due dates.

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SPT Membership

While the designated resident is in a nursing facility, the SPT must include:

- The designated resident and the designated resident's LAR, if any;
- The habilitation coordinator for discussions and service planning related to specialized services;
- The managed care organization (MCO) SC, if the designated resident does not object;

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SPT Membership-Continued

While the designated resident is in a nursing facility, the SPT must include:

- A representative from the local mental health authority (LMHA) or local behavioral health authority (LBHA), if the designated resident has mental illness (MI);
- A nursing facility staff person familiar with the designated resident's needs; and
- A person providing a specialized service to the designated resident or a representative of a specialized services provider for the designated resident.

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Additional SPT Members

If the designated resident is transitioning to the community, the SPT Team must now include:

- The service coordinator;
- A representative from the community program provider, if one has been selected; and
- A relocation specialist.

Other participants on the SPT may include:

- A concerned person whose inclusion is requested by the designated resident or the LAR; and
- At the discretion of the LIDDA, a person who is directly involved in the delivery of services to people with intellectual disability (ID) or developmental disability (DD).

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Developing Individual Profile and Habilitation Service Plan

The Individual Profile contains key information about a person who receives PASRR specialized services.

The Individual Profile and the HSP must be completed at the initial IDT/SPT meeting and kept up-to-date throughout the plan year.

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Habilitation Service Plan Content

The HSP includes all specialized services (including habilitation coordination) agreed upon during the IDT/SPT meeting.

At a minimum, for each specialized service agreed upon during the IDT/SPT meeting, the HSP must indicate either:

- An assessment will be conducted; or
- The amount, frequency and duration of the specialized service to be provided.

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Individual Profile and Habilitation Service Plan

The HSP is a plan developed by the SPT while a person receiving services is residing in a nursing facility (NF) that:

- Is individualized and developed through a person-centered approach;
- Identifies the person's:
  - Strengths;
  - Preferences;
  - Desired outcomes; and
  - Psychiatric, behavioral, nutritional management and support needs as described in the comprehensive care plan or minimum data set assessment; and
- Identifies the specialized services that will accomplish the desired outcomes of the resident, or the LAR's on behalf of the person receiving services, including amount, frequency and duration of each service.

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The Habilitative Assessment

The Habilitative Assessment is used by the HC to:

- Guide discussion relating to PASRR specialized services;
- Document results of discovery; and
- Document the HC's recommendations for specialized services.

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Monitoring and Follow-up Activities

Monitoring may be accomplished through a combination of:

- Face-to-face contacts, unless waived by HHSC;
- Observation of the person receiving services;
- Conversations with the person, LAR, NF staff, and provider;
- Review of documentation, service delivery logs, or written reports from a provider; and
- Regular observation of the person in any environments they frequent.

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Monitoring

Monitoring and follow-up activities determine:

- Whether a person receives the specialized services agreed upon in an IDT or SPT meeting and follow up when delays occur;
- Whether a person's HSP is fully implemented;
- A person's and LAR's satisfaction with all specialized services; and
- A person's progress or lack of progress toward achieving goals and outcomes identified in the HSP.

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Bridging the Relationship

PASRR remains a collaborative effort between the local authorities and the NFs.

This collaboration is most observable when comparing the NF's comprehensive care plan with the LIDDA's planning documents.

The HC facilitates the coordination of the designated resident's HSP and the comprehensive care plan, including ensuring the HSP is shared with members of the SPT and the NF.

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Community Living Options (CLO)

An HC provides information and discusses with the person and LAR about the range of community living services, supports ,and alternatives.

An HC identifies the services and supports the person will need to live in the community (whether the individual/LAR has chosen to transition to community living) and identifying and addressing barriers to community living. This activity is referred to as "CLO."

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Community Living Options

- For a person whose diagnosis of ID or DD has been confirmed, the staff conducting the PE must present CLO.
- CLO must be presented in a manner that allows the person and their LAR to fully understand the options available.
- CLO duration may vary but should last as long as needed to completely and meaningfully present all available community living options.

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CLO Materials Provided to Individual/LAR

- Making Informed Choices: Community Living Options Information Process for Nursing Facility Residents booklet.
- Making Informed Choices: Community Living Options Information for Legally Authorized Representatives of Residents of Nursing Facilities booklet, if they have an LAR.
- Long Term Services and Supports, Appendix II in the LIDDA Handbook.
- Explanation of Services and Supports.
- Friends and Family Guide to Adult Mental Health Services.

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Transition Planning Responsibilities

When a person/LAR indicates interest in community living, the Habilitation Coordinator processes a referral to the relocation specialist (RS) through the MCO.

An RS is an employee or contractor of an MCO who provides outreach and relocation activities to people who are PASRR Positive for ID or DD, living in NFs, and expressing a desire to transition to the community.

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Working with the Relocation Specialist

The following steps are completed by the HC following the person/LAR's decision to pursue community living:

- HC sends Referral for Relocation Services to the person's MCO.
- The RS completes an assessment and evaluation and gives a copy to the HC.
- The HC reviews the RS's assessment and evaluation to determine if specialized services can assist the person with transitioning to the community. If so, the HC convenes a meeting with the SPT.

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HC's Next Step in Transition Planning

If the person/LAR selects a community program, then the HC:

- Notifies the LIDDA and SC/ECC is assigned;
- Provides a copy of the relocation assessment and evaluation to the SC/ECC;
- Provides a copy of the person's habilitation packet to the SC/ECC;
- Informs the RS of the name and contact information for the SC/ECC who will facilitate transition planning for the person; and
- Continues providing Habilitation Coordination until the person discharges from the NF.

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HC's Next Step in Transition Planning-Continued

If the person/LAR has not selected a community program, then the HC:

- Shares a copy of the habilitation packet with the RS;
- Works with the RS to assist the person/LAR in selecting a community program that best suits the person's needs; and
- Ensures that barriers to selecting a community program are identified in Section 7 of the HSP.

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Transition Planning

Service Coordination

Enhanced Community Coordination

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Transition Planning and Service Coordination

Service Coordination begins when a habilitation coordinator notifies the appropriate LIDDA staff that a person/LAR wants to transition to the community and has selected a community program.

Within seven days after notification by an HC:

- The LIDDA assigns an SC/ECC to the person and ensures the assigned SC/ECC is identified in CARE screen 490; and
- The assigned SC/ECC meets face-to-face with the person and LAR to describe the transition planning process and gain an understanding of the person's/LAR's perspective of community living.

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Transition Planning

SCs/ECCs are responsible for:

- Facilitating diversion for persons at risk of admission to an NF;
- Convening and facilitating SPT meetings to develop and implement the person's Transition Plan within 10 days after the SPT meeting;
- Reviewing the relocation assessment and evaluation;
- Working with the relocation specialist and MCO SC; and
- Developing and revising a diversion or transition plan, as necessary.

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Transition Planning-Continued

SCs/ECCs responsibilities (continued):

- Documenting the SPT discussions and decisions in a progress note;
- Developing and revising the HCS Person-Directed Plan, as necessary;
- Conducting a pre-move site review and at least three post-move monitoring visits for persons enrolling into HCS and a community Medicaid program;
- Monitoring activities for one-year post-move (for people moving to HCS).

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Transition Planning Documents

A transition plan must identify the services and supports a designated resident needs to live in the community, including those essential supports that are critical to the designated resident's health and safety.

Pre-move reviews and post-move monitoring are conducted to ensure those essential supports are in place at the time of the person’s move to the community.

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Pre-Move Site Review

- Prior to a person's transition, the SC/ECC documents the community provider information and essential supports.
- The SC/ECC is responsible for ensuring the essential supports identified are in place before a person's projected transition date.
- At the time of the review, if any of the essential supports are not in place, or if issues are raised about the suitability of the site, the person's SPT must reconvene to discuss and resolve all outstanding issues.

Post-Move Monitoring

- The SC/ECC conducts a post-move monitoring visit at least three times within the first 90 days after the person transitioned or diverted.
- The SC/ECC is responsible to ensure the essential and non-essential supports are still in place during post-move monitoring.
- The SC/ECC must provide an explanation of the provider's justification for discontinuing the support, whether it has had an adverse impact on the person and, if so, describe the adverse impact.

Need Answers?

Habilitation Coordination:

For questions regarding habilitation coordination or habilitation coordinator questions contact:

IDD-BH_PASRRSPA@hhsc.state.tx.us

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Thank you

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