PASARR DESIGN TEAM

DRAFT Improvement – Electronic 3877 & 3878 Forms

Stakeholder Feedback Sessions October/November 2018

This Presentation will be posted to **https://www.osapartner.net** for your review.

Michigan's LTSS Quality Improvement Initiative - Background

- No Wrong Door (NWD) –Aging and Disability Resource Centers
- Special Message on Aging – Charge by Governor to Improve LTSS
- Meeting of LTSS State Government Representatives
- Charter to Collaborate Signed by DHS, DCH, LARA and OSA
- Federal Planning Grant to Create NWD System at State Level
- Creation of the BOLD Council – Collaboration, Coordination, Streamlining and Integration
- Introduction to Lean Continual Process Improvement
- Value Stream Mapping of 18 LTSS

Michigan's LTSS Quality Improvement Initiative - Background

- MDHHS Executive Leadership and Sponsor Selection of Services to Undergo Process Improvement
  - Adult Protective Services (APS) Design Team
  - Home Help Design Team
  - MI Choice Waiver Design Team

Michigan's LTSS Quality Improvement Initiative - Background

- Other Current Design and Action Teams
  - **Pre-Admission Screening and Resident Review (PASRR)**
  - Person Centered Planning (PCP)
  - Nursing Facility Transition (NFT) – State-level Design and 4 Action Teams,
  - Michigan Rehabilitation Services (MRS)
  - Options Counseling
  - Level of Care Determination (LOCD)
  - Civil Money Penalties (CMP)
  - Transfer Trauma

Michigan's LTSS Quality Improvement Initiative – Background

- Design Team Responsibilities
  - Meet Weekly
  - Attend Weekly Stand and Deliver
  - Monthly Executive Sponsor Meetings
  - Review Ideas for Improvement generated by Value Stream Mapping (and others), conduct Plan, Do, Study, Act (PDSA) Cycles to test hypotheses, pilot ideas for improvement and gather stakeholder input, repeat
  - Stakeholder Input – the Purpose for today's meeting

Old School.

vs.

Highly Efficient.

PASARR Design Team
AIM AND PURPOSE STATEMENT:

- *"Our aim is to update, standardize, and improve the PASARR process. The purpose is to make forms electronic and decrease paperwork as well as increase compliance and efficiency."*

Michigan Department of Health and Human Services (MDHHS)

Long-Term Supports & Services (LTSS)

Continual Quality Improvement (CQI) Initiative

Pre-Admissions Screening & Resident Review Design Team Aim & Purpose:

"Our aim is to update, standardize, and improve the PASRR process. The purpose is to make forms electronic and decrease paperwork as well as increase compliance and efficiency."

Design Team Member	**Agency**
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Stephanie Stearns, LMSW stearnss@ewashtenaw.org	Washtenaw County OBRA Coordinator/Supervisor
Connie Youngert youngertc@michigan.gov	Division of Quality Management and Planning, MDHHS, Office of Specialized Nursing Home/OBRA Program
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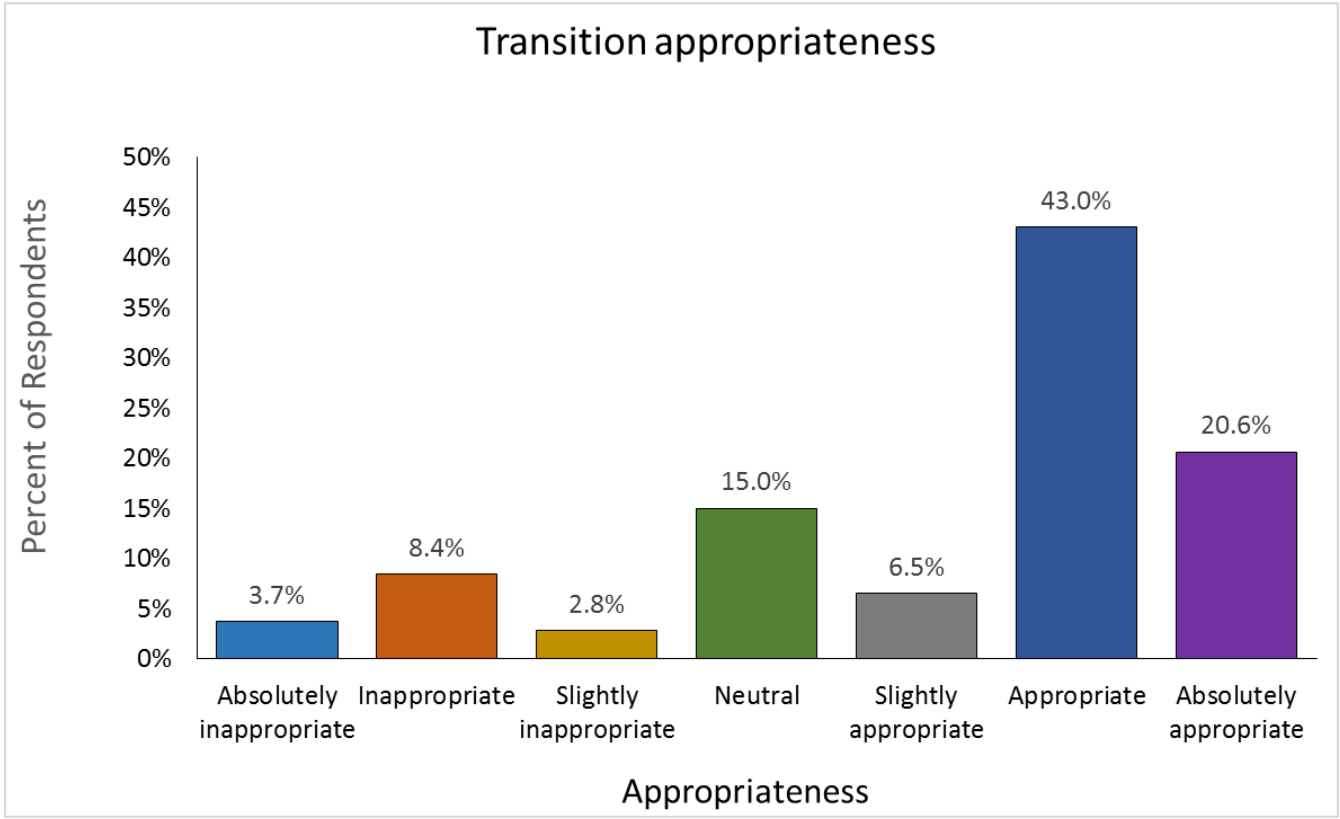
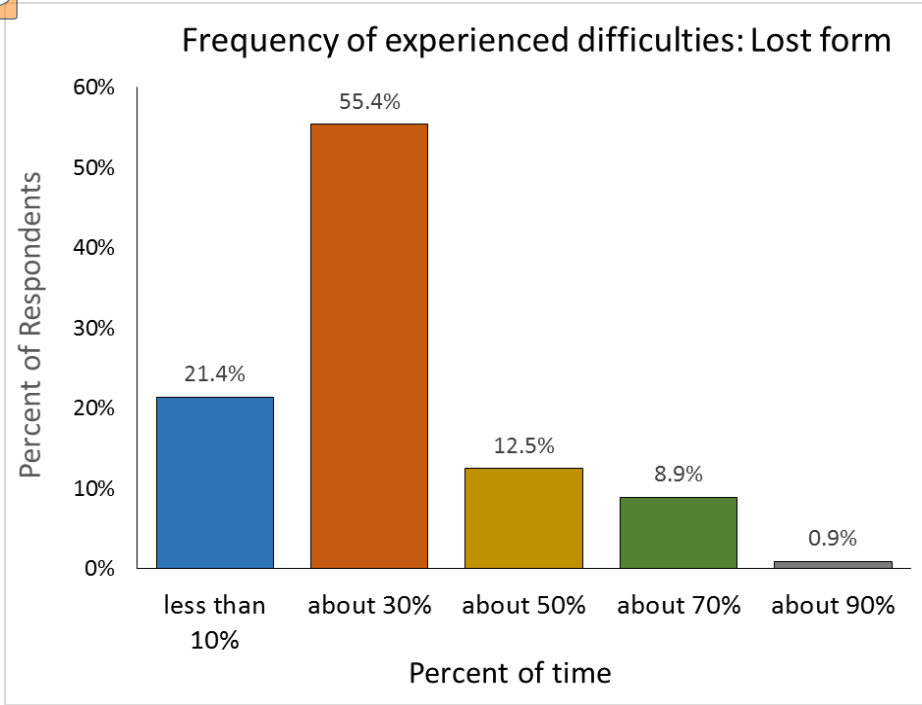
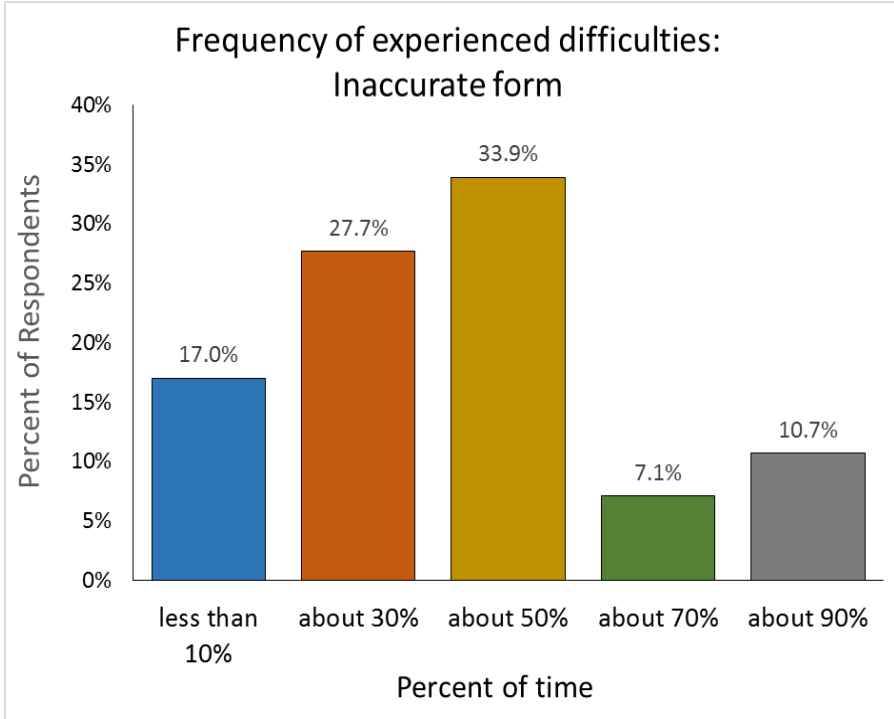
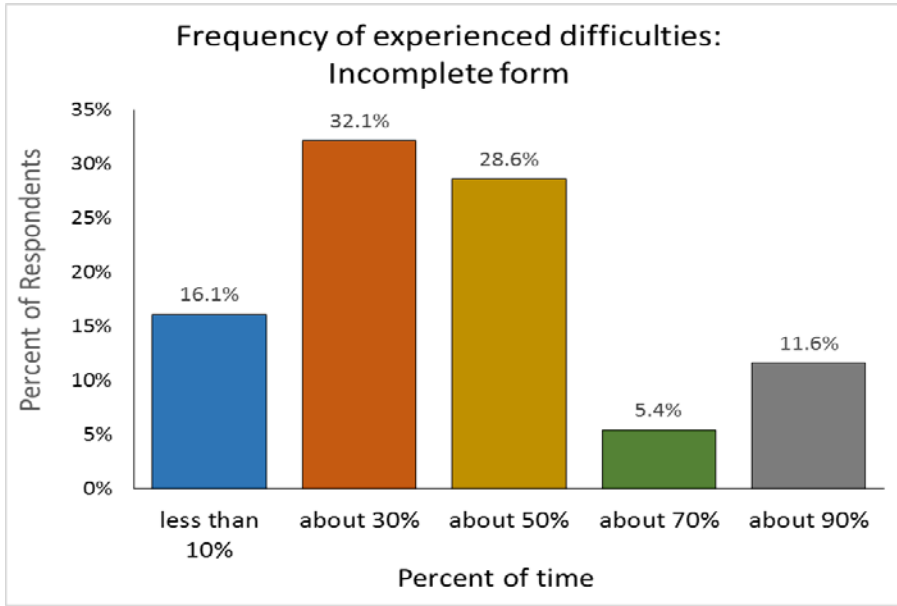
What You Had To Say



70.1% of those surveyed indicated transitioning to electronic forms is appropriate.







- Three major barriers of the current format are lost, inaccurate and incomplete forms.
- These barriers have been addressed in the idealized design.

Feedback from States who have transitioned to electronic forms…

- The PASARR Design team researched multiple states to receive feedback regarding their transition to an electronic PASARR process.
  - States had similar barriers to transitioning to the electronic process.
  - Successes have been incorporated
  - Positive feedback has been received several years post implementation

What will the electronic process improve?

- **IMPORTANT: THE 3877/78 FORMS HAVE MINIMAL CHANGES!!**
- They looked longer/more complicated on the survey due to inability to translate "behind the scenes" IT issues. (auto-fill, stops)
- The proposed changes will allow the process to function as intended.

3877 DRAFT Form

DRAFT

(Mental Illness/Intellectual Disability/Related Conditions Identification)
Michigan Department of Health and Human Services

(PAS, ARR, CIC will have drop down box for when to use)

1. **Level I Screening** PAS ARR CIC

SECTION I - Patient, Legal Representative and Agency Information

2. Social Security Number *If not present don't stop submission Must enter first so auto populates Stop - name, DOB, inst#'s	3. Consumer Name (First, MI, Last) Auto-populate	4. Date of Birth (MM/DD/YY) Auto-populate	5. Gender Auto-populate
6. Mailing address (number, apt. or lot #)	7. Is this permanent mailing address? Yes vs No Checkbox	8. County of Residence	9. Consumer phone number
1 City pop up box certifying that address is current	11. State Dropdown	12. Zip Code	13. Medicaid Beneficiary ID Number Not required fields
14. Medicare ID Number Not required fields			
16. Name of Legal Representative Is there a legal rep check box, if so then ask for these fields. We will need a 3877 DPOA	17. If DPOA is it activated? Not required field unless DPOA present	18. Today's Date Auto-populate from system date (Remove)	19. Consumer/ Legal Rep agreed to placement ☐ Yes ☐ No
20. Check to indicate that legal representative papers have been uploaded When box is checked popup, box allows uploads	21. Address (number, street, apt. number or suite number) Not required field unless DPOA present		
22. Legal Representative Telephone Number Not required field unless DPOA present	23. City Not required field unless DPOA present	24. State Not required field unless DPOA present	25. Zip Code Not required field unless DPOA present
26. Referring Agency Name Drop down or other with free form	27. Telephone Number	28. Admission date to nursing facility	
29. Nursing Facility Name (proposed or actual) Nursing Facility	30. County Name Auto-populate from nursing facility name		
31. Nursing Facility Address (number and street) Auto-populate	32. City Auto-populate	33. State Auto-populate	34. Zip Code Auto-populate

Sections II and III of this form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or a physician.

SECTION II - Screening Criteria (All 6 items must be completed.)

35. 1	The person has current diagnosis of:	☐ Mental illness	☐ Dementia	☐ Both	☐ Yes	☐ No
36. 2	The person has received treatment for: (i.e. restraints, medications) (within past 24 months)	☐ Mental illness	☐ Dementia	☐ Both	☐ Yes	☐ No
37. 3	The person has routinely received one or more prescribed antipsychotic or antidepressant medications with the last 14 days (will discuss routinely definition)				☐ Yes	☐ No
38. 4	There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgement. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others.				☐ Yes	☐ No
39. 5	The person has a diagnosis of an intellectual disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22.				☐ Yes	☐ No
40. 6	There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual disability or a related condition. These deficits appear to have manifested before the age of 22.				☐ Yes	☐ No

** Explain any Yes's. If all no's checked - goes to Signature, then goes to NH queue

****Note:** If you check "Yes" to items 1 and/or 2, check the word **"Mental Illness" and/or "Dementia" or "Both"**

41. **Qualifies for Coma, Dementia or hospital exempt Discharge?** If yes is checked the user is routed to the 3878 and information is auto populated from this form.	☐ Yes	☐ No
42. Explain any Yes - include all mental health drugs and reason for taking Auto-stop - detects if any "yes" detected in 1-6		
43. **Note:** The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria.		

SECTION III - CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate

44. Clinician Signature E-signature	45. Date Auto populate from system date	46. Name (type or print) Auto-populate from system credentials
47. Address (number, street, apt. number or suite number) Auto-populate from system credentials	48. Degree/License Auto-populate from system credentials	
49. City Auto-populate from system credentials	50. State Auto	51. Zip Code Auto / 52. Telephone Number Auto-populate from system credentials

53. **AUTHORITY:**	54. Title XIX of the Social Security Act is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.	55. The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
56. **COMPLETION:**		

57. **DISTRIBUTION: If any answer to items 1-6 in SECTION II is "Yes", send ONE copy to the local Community Mental Health Services Program (CMHSP) with a copy of form DCH-3878 if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.**

58. **Can't submit unless all fields are complete

59. ☐ APPROVE

60. Submit → Forwards form to doctor with 3878 or forwards to NH

61. **Once CMH opens the form this section will populate:**

62. Date Stamp (Referral Date)

DCH-3877 (Rev. 8-17) Previous edition obsolete

63. ☐ Significant Mental Illness - Continue to — **Auto-generate**

64. ☐ Not Significantly Mentally Ill (nsmi) - letter sent

65. ☐ Planned Discharge

66. ☐ Deferred - not due

67. ** Must enter ID for access box pop ups?

68. **Will auto-populate level 1 information to set up level 2?

3878 DRAFT Form

DRAFT

HOSPITAL EXEMPTED DISCHARGE (HED)
MENTAL ILLNESS/INTELLECTUAL DISABILITY OR RELATED CONDITION
EXEMPTION CRITERIA CERTIFICATION

Michigan Department of Health and Human Services
For Use in Claiming Exemption Only
Do Not Send in if Level II Screening Required

EXEMPTIONS
DCH-3878

A 3877 must be filled out to get to the 3878

1. Consumer Name Auto-Populate from 3877	2. Date of Birth Auto-Populate from 3877	
3. Name of Referring Agency Auto-Populate from 3877	4. Referring Agency Telephone Number Auto-Populate from 3877	
5. Referring Agency Address (Number, Street, Building, Suite Number, etc.) Auto-Populate from 3877	6. State Auto-Populate	7. Zip Code Auto-Populate

Exemption Criteria

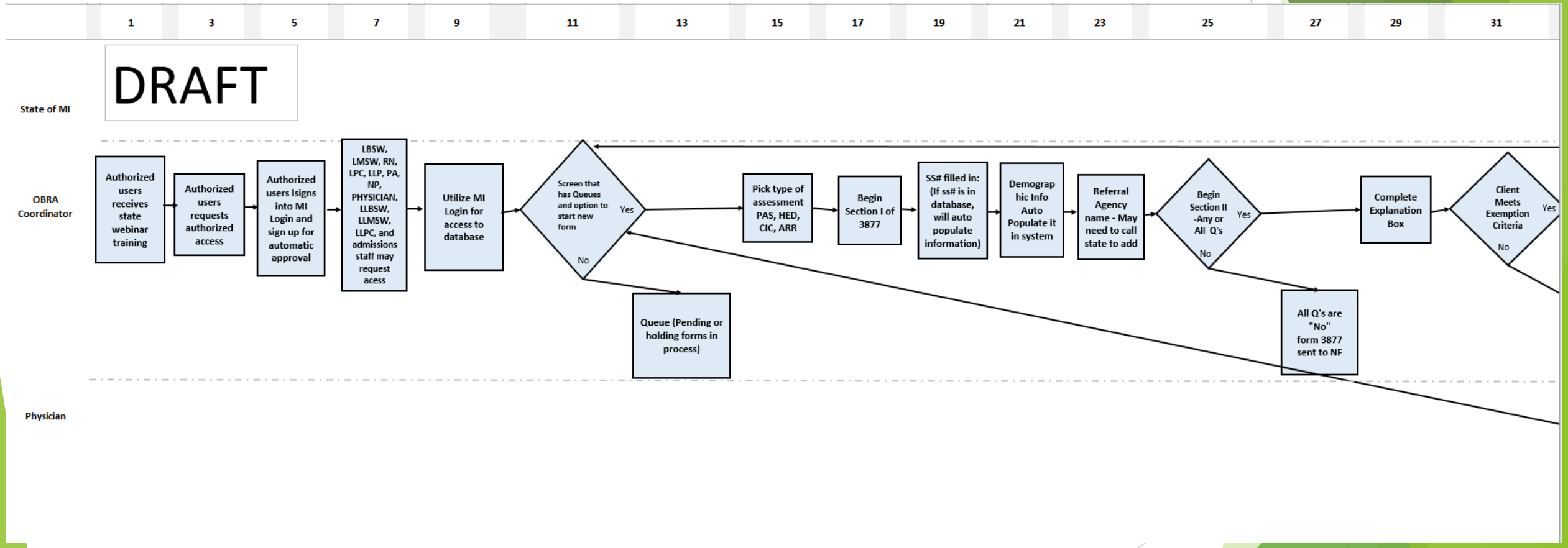
8. **COMA:** I certify the patient under consideration is in a coma/persistent vegetative state. If YES take to signature/ If NO go to Dementia	☐ Yes	☐ No
9. **DEMENTIA:** I certify the patient under consideration has dementia as established by clinical examination and evidence of meeting ALL 5 criteria below. If NO go to HED Hover over	☐ Yes	☐ N
10. I certify the patient under consideration does not have another primary psychiatric diagnosis of a serious mental illness. Hover mental illness definition Or * underneath	☐ Yes	☐ N
11. **I certify the patient under consideration does not have an intellectual disability, developmental disability or a related condition.** If YES continue/ If NO stop from going forward - Message indicating 3878 not required. Return to home screen.	☐ Yes	☐ N
Specify the type of dementia Provide Definitions - Need to verify Definitions		
12. 1. Has demonstrable evidence of impairment in short-term or long-term memory as indicated by the ability to learn new information or remember three objects minutes, and the inability to remember past personal information or facts of common after five knowledge. YES or NO proceed to question 2	☐ Yes	☐ N
13. 2. Exhibits at least one of the following: **(Check all that apply)**		
13A. a. * Impairment of abstract thinking, as indicated by the inability to find similarities and differences between related words; has difficulty defining words, concepts and similar tasks.	☐ Yes	☐ N
13B. b. * Impaired judgment, as indicated by inability to make reasonable plans to deal with.	☐ Yes	☐ N
13C. c. * Other disturbances of higher cortical function, i.e., aphasia, apraxia and constructional interpersonal, family and job-related issues.	☐ Yes	☐ N
13D. d. * Personality change: altered or accentuated premorbid traits.	☐ Yes	☐ N
14. 3. Disturbances in items 1 or 2 above significantly interfere with work, usual activities or relationships with others. YES go to question 4/ NO Stop - Message indicating 3878 not required. Return to home screen.	☐ Yes	☐ N
15. 4. The disturbance has NOT occurred exclusively during the course of delirium. YES go to question 5/ NO Stop - Message indicating 3878 not required. Return to home screen.	☐ Yes	☐ N
16A. 5a. Medical history, physical exam and/or lab tests show evidence of a specific organic factor judged to be etiologically related to the disturbance, OR YES go to question b)/ NO go to Signature	☐ Yes	☐ N
16B. 5b. An etiologic organic factor is presumed in the absence of such evidence if the disturbance cannot be accounted for by any non-organic mental disorder. YES or NO proceed to Signature	☐ Yes	☐ N
17. **HOSPITAL EXEMPT DISCHARGE (HED): Yes,** I certify that the consumer under consideration:		
17A. a) is being admitted after a medical in-patient hospital stay. YES go to question 2)/ NO Stop - * Cannot be from OBS/Psych/Home/ED	☐ Yes	☐ N
17B. b) requires nursing facility services for the condition for which he/she received hospital care (physical or occupational therapy or IV therapy), **AND** YES go to question 3)/ NO Stop - Message indicating 3878 not required. Return to home screen.	☐ Yes	☐ N
17C. c) is likely to require less than 30 days of nursing facility services. YES go to Signature/ NO Stop - Message indicating 3878 not required. Return to home screen.	☐ Yes	☐ N

18. Physician/Physician's Assistant/Nurse Practitioner Signature Auto-populate from system credentials	19. Date A-P from system date	20. Name (Typed or Printed) Auto-populate from system credentials
21. **AUTHORITY:**		
22. **COMPLETION:**		
23. Title XIX of the Social Security Act is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.		
24. The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.		
25. ☑ Approve		
26. Date Stamp Auto-populate with system date when the user checks the I approve box and submits.	26. Submit	**Can't submit unless all fields are complete 3878 Letters TBD

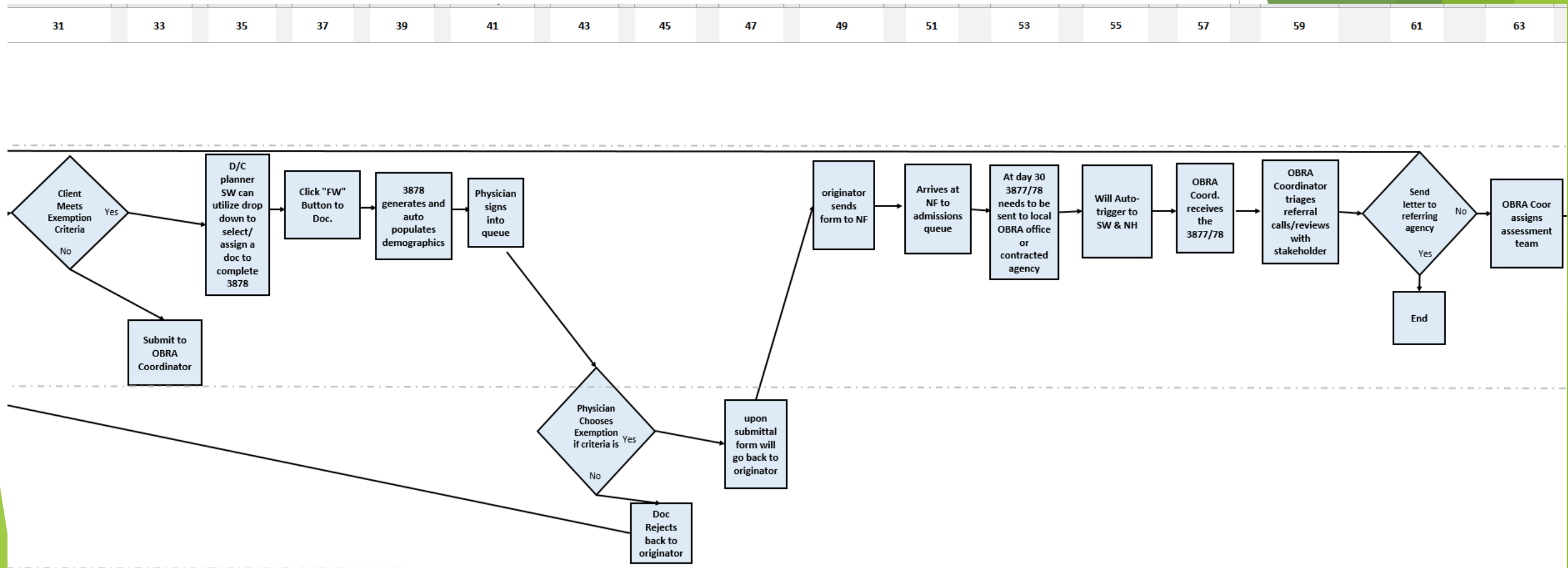
What is an idealized design?

- Draft re-design of an improved process.

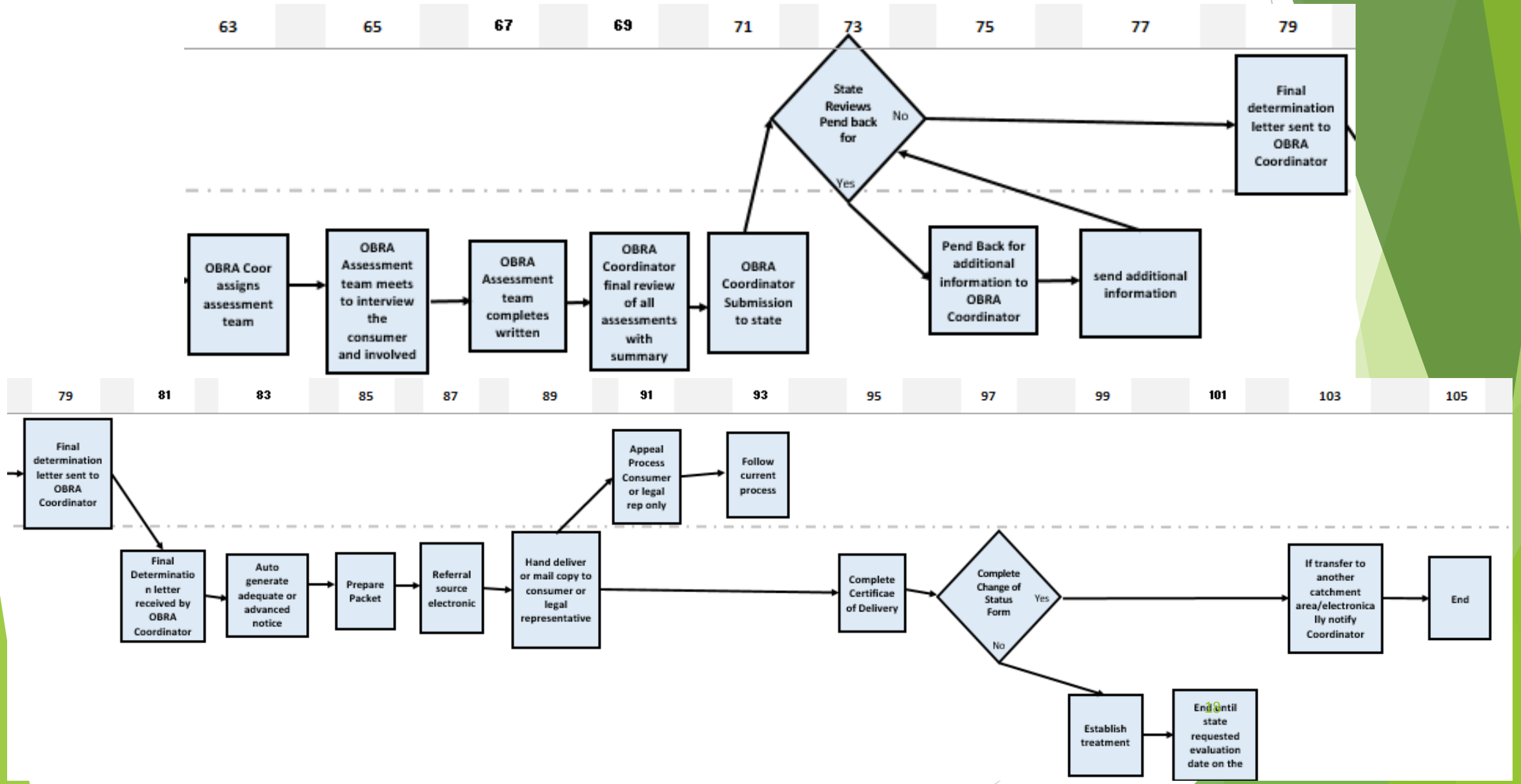
Idealized Design



Idealized Design 2 of 3



Idealized Design 3 of 3



Training

- Webinar training will be provided to all users.
- The Design Team is currently exploring in person OBRA Coordinator training made available prior to going live.
- Training will cover:
  - The 3877 and 3878 (accessible through MI Login).
  - Establishing a user name/password
  - How to navigate the electronic system
  - Who will provide trouble-shooting

Implementation

- The team proposes that a pilot will begin in early Spring of 2019 with several pilot sites around the state.
- Five diverse sites across the state have volunteered to pilot the transition to an electronic form.
- Statewide rollout to tentatively be held in Summer 2019.
- All sites will receive ample notification prior to the statewide rollout.

Next Steps

- Incorporate Stakeholder feedback into Idealized Design
- Post feedback responses on www.osapartner.net for stakeholder review
- Propose Idealized Design to IT
- Adjustments/updates to be made to the Idealized Design based on IT recommendations.
- Pilot sites will test the new process and provide feedback, comments and recommendations.
- Feedback will be taken into considerations to identify improvements with implemented enhancements made.
- Implementation will expand within the state in small and manageable increments.

How do we know the change is an improvement?

- Post implementation a follow up survey will be sent out statewide to gather information regarding your experiences with the transitions.
  - These experiences will be used to look at needed improvements and/or adjustments to the process.

Recap

- Your Sticky Note Feedback will be compiled and Design Team will review and categorize it
- Feedback will be posted on the OSApartner.net website
- Pilots of new electronic form will be conducted – pilot site volunteers have already been identified
- Improvements based on pilots will be built into new form/process
- Finalized, process and policy - Implementation projected for Summer of 2019
- Continual Quality Improvement Built into Implementation

Thank you for your feedback and your time!!!

The Presentation & Responses to Comments/Feedback can be found at:

- WWW.OSAPartner.net