Welcome

Navigating Care Transitions:
Supporting Residents with Opioid Use Disorder

May 21, 2025

Healthcentric Advisors
Advancing Healthcare Quality | Empowering People

Acknowledgement

This presentation was made possible by funding from the Connecticut Department of Mental Health and Addiction Services. We would also like to thank representatives from Connecticut Department of Mental Health and Addiction and Connecticut Department of Public Health for their contributions in the training and implementation of this initiative.

Logistics for Today's Webinar

- Enter your name, organization, and the number and names of people joining you today in the chat.
- Participants' microphones will be muted until the question and discussion session.
- Use the chat feature to enter any questions you have; we will address questions at the end of the presentation.
- The slides and video will be posted here: https://healthcentricadvisors.org/learning-resources/ct-ltc-oud/

You Are Invited…

- To be open, impacted, and changed by what you hear.
- You should speak from your own personal experience, from the “I” perspective, rather than speaking generally for others.
- Be patient with each other as we all strive to use respectful and person-centered language. Terminology evolves, and this is a work in progress for all of us.
- You must demonstrate self-awareness regarding the amount of airtime you use and balance your contributions with those of other participants.
- To share a story, provide the headline version with only relevant details that support learning for all.

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Learning Objectives

1. Identify the importance of seamless transitions for residents with Opioid Use Disorder.
2. Discuss Preadmission Screening Resident Review (PASRR).
3. Review programs available through CT DMHAS including the Nursing Home Diversion and Transition Program.
4. Identify supportive housing resources available for residents in long-term care.

Chat in..

What is the biggest challenge you have encountered in caring for residents with OUD as it relates to care transitions?

For experienced providers: chat in one “pearl of wisdom” for safely transitioning a resident with OUD

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Erin Leavitt-Smith, Director Statewide Services
Connecticut State Department of Mental Health and Addiction Services

Who Must Have a Pre-Admission Screening and Resident Review (PASRR) Screening

- Any individual who is seeking Medicaid payment for an SNF stay
- Individuals 65 and older who are Medicaid active, eligible, or pending who are seeking SNF placement
- All individuals seeking SNF admission who have a positive level 1 and are determined by level 2 evaluation to have a PASRR target condition, i.e, serious mental illness or a developmental disability
- PASRR Screenings completed by staff at Maximus Management
- Level 1 is the first screening completed

PASRR Purpose – Federal Law

- Purpose: To ensure that SNF applicants and residents with serious mental illness and/or intellectual disabilities are :
- Identified
- Placed appropriately
- Admitted or allowed to remain in a SNF only if they can be appropriately served there
- Provided with the treatment services they need including specialized services
- For a SNF to be considered an appropriate option the individuals must meet criteria for SNF level of care & total needs, including disability needs, must be best served in a nursing facility

Level 1 Federal Requirements

- Identifies persons with intellectual and developmental disabilities
- Identifies persons with serious mental illness
- Identifies applicants who are eligible for level 2 evaluations
- If Dementia is the only psychiatric condition, PASRR does not apply
- If Dementia co-occurs with a mental illness, then the dementia must be far more progressed than the mental illness for PASRR to exclude the person
- Dementia diagnosis' need to have supporting documentation such as testing, MoCA, BCAT

Level 2 Requirements

- Level 2 assessment is required when prior to SNF admission, a serious mental illness is present
- Once the individual is identified as needing a level 2 Maximus will request, per federal requirements:
  - H&P (completed in the past 12 months)
  - Physicians orders & treatment
  - Current medication list
  - Contact information for family, COP/E, PCP
  - Admitting SNF if known
  - Any additional information that may clarify the individual's mental illness or physical state

SNF Level of Care

- The presence of an uncontrolled/unstable or chronic medical condition requiring continuous skilled nursing services
- A chronic condition requiring substantial assistance with personal care on a daily basis
  - Chronic condition plus 3 ADL needs
  - Chronic condition plus hands-on assistance w/2 or more ADLs plus a need factor
  - Dementia diagnosis that requires a structured, professionally trained staffed environment for daily monitoring
- Physical Functional Ability
  - ADL needs: bathing, dressing, toileting, transferring, ambulation
  - Supervision, cuing, hands-on support, dependence
- Health Issues / Medical Needs
  - Assistance with medical care such as injections, catheters
- Cognitive Impairment
  - Neurocognitive issues that result in impaired judgement, inability to make appropriate and/or safe decisions, and there is potential danger if living independently without supervision and assistance.
- Behavioral Problems
  - frequent wandering from the home and becoming lost, impulsiveness, aggressiveness (physical, verbal).

ADL Measurements

- Independent/supervision less than daily
  - Independently accomplishes activities that assures health/requires supervision less than daily
- Supervision/cuing daily
  - Requires support i.e, monitoring, observing, verbal or physical prompting and/or coaching daily
- Hands-on support
  - Physical assistance/intervention from another person to initiate or complete tasks that ensure health and safety
- Total dependence
  - Incapable of performing the task without assistance from another person(s)

Need Factors

- Rehabilitation services 5x/week (PT, OT, SP, RT)and the individual is determined to have restorative potential
- Requires a caregiver daily for supervision to prevent harm due to severe cognitive impairment in one or more of the following: memory orientation, judgement, communication
- Due to Dementia, requires supervision by another person at least daily to prevent harm in one or more of the following: Assaultive behavior, unsafe/unhealthy hygiene habits, wandering, threats to health/safety
- Requires assistance of another person with physician ordered daily medications. Assistance includes supports beyond set-ups and may include verbal instructions, coaching, pointing, or physical assistance with some or all physical steps of taking daily medication

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Amy Dumont, LCSW,
Behavioral Health Clinical Supervisor
Nursing Home Diversion and Transition Program/
Senior Outreach and Engagement Program

Nursing Home Diversion and Transition Program (NHDTP)

- **Program Goals**:
  - Diverting individuals from institutional levels of care
  - Ensuring that nursing home placements for DMHAS clients are necessary, appropriate, and safe
  - Transitioning nursing home residents with a serious mental illness back to the community
  - Diverting individuals from ED's & avoiding unnecessary acute care hospitalizations
  - Consultations with CVH, community providers, medical personnel, and state partner staff

Nursing Home Diversion and Transition Program (NHDTP)

- 8 nurses & 3 case managers cover the 5 DMHAS regions
  - Provide consultation to nursing home discharge staff regarding behavioral health options in the community
  - Consult with community providers regarding:
    - medical issues such as diabetes education, healthy lifestyle choices
    - mental health service linkage
    - substance use treatment & linkages including MAT & MOUD
    - RCH placement
  - Ongoing collaboration with Money Follows the Person & Mental Health Waiver
  - Assessment for level of care to determine the most appropriate community-based residential option

Nursing Home Diversion and Transition Program (NHDTP)

- The NHDTP program collaborates with the CT Association for Residential Care Homes (CARCH) :
- Develop curricula for training RCH direct care staff to serve residents better. Trainings topics: Mental illness 101, Establishing Professional Boundaries and Avoiding Power Struggles, Crisis Stabilization and De-escalation Bullying in Congregate Care Settings, Substance Use and Addictions, The Mind, Body, Spirit Connection (Self Care), Working with People with Intellectual Challenges, Working with People with Alzheimer's Disease and Dementia, Diabetes 101, Fall Risk and Prevention, and Recovery Transformation Topics
- Assist with residents who are in crisis by assessing clients for the most appropriate level of care; act as liaison between the residential care home and the hospital emergency department
- Assist in the emergency placement of RCH residents and coordinate with DPH, DSS, and the State Long Term Care Ombudsman program in securing alternative housing.

Senior Outreach & Engagement

- Mission: To outreach and engage at-risk older adults with behavioral health and substance use disorder treatment needs
- Program capacity covering all 5 DMHAS regions; expansion in March 2023
- Provides outreach through visits to residences, nursing homes, senior centers and other community locations
- Assist people in navigating mental health and substance disorder treatment system
- Assist with linkages to all levels of treatment services to help older adults “age in place” and avoid unnecessary institutionalization

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DMHAS Nursing Home Diversion and Transition Program

REQUEST for DIVERSION NURSE SERVICES

Date of Request: _____ Client Name: _____ DOB ___/___/____

Insurance: ☐ No or list Medicaid (ID#_____) Medicare (ID#_____)

Other Insurance: _____ SS# _____

Conservator: ☐ No ☐ COP ☐ COE ☐ Both COP/COE Name/Number: _____

Current Client Address:_____ Telephone: _____

Diagnosis: _____

Does the Client AND Conservator consent to this referral request? YES _____ NO _____ (client /COP must be informed prior to receiving Diversion Nurse Services)

****

TYPE OF REQUEST

☐ **MFP Client** (check one below to identify status) Name of current facility: _____

- ☐ Expected to transition to a HCBS waiver: Specify Waiver _____
  Anticipated Transition Date _____
- ☐ Expected to transition to State Plan Services: Anticipated Transition Date _____
  Address:_____ Telephone: _____
- ☐ Client's transition status is unclear
- ☐ Other: Require consultation to establish plan _____

****

☐ **Non-MFP Client** (resides in community already)

Is client on a Waiver ☐ yes ☐ no If yes, which one: _____

Community Supports/involved family or friend? ☐ yes ☐ no If yes, please provide name, contact number, and type of involvement: _____

Reason for Request (What do you want the Diversion Nurse to do? Please be SPECIFIC)

Current Providers

Mental Health: _____

_____

Medical Providers: _____

_____

_____

**********PLEASE PRINT ONLY IN NEXT SECTION**********

Person Making Request _____ Relationship _____

From _____

(name of agency; hospital; address)

Telephone _____ Email _____

Fax completed form to the Program Manager or Admin. Assistant (Mary Ives) at fax number (860) 262-5852 or via email at MHW-DMHAS@ct.gov

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Mollie Machado, MBA, Behavioral Health Program Manager
Connecticut Mental Health and Addiction Services
Housing & Homeless Services, Statewide Services Division

Housing & Homeless Services in Connecticut

April 2025

Mollie Machado, Program Manager
Dept of Mental Health and Addiction Services, Office of the Commissioner,
Statewide Services Division

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Causes of Homelessness

* Lack of Affordable Housing
* Lack of Prevention Supports
* No social supports
* Prolonged institutional stays (hospital, incarceration, residential treatment)
* Limited Income

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How many people are housing insecure?

* Our best data on housing insecurity statewide comes from 211, where housing calls are their most frequent inquiries.
* From July 1, 2023-June 30, 2024 211 received 539,190 requests for housing and shelter related calls.
* Because most federal resources are reserved for folks experiencing homelessness, there are very limited resources for folks at-risk of homelessness. HUD has very strict definitions of homelessness, and as the funder, our programs can only serve eligible populations.

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HUD Definition of Homelessness

* **Literally Homeless***
  * Living in a shelter, place not meant for human habitation (unsheltered), hotel paid for by government or charity, or in an institution for 90 days or less, and was in one of the other settings the night before the institutional stay.
* Imminent Risk of Homelessness
* Homeless under other federal statutes
* **Fleeing or attempting to flee domestic violence***

Most of the homeless service programs in CT can only serve folks who are literally homeless or fleeing DV, per funder regulations

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Connecticut's Point In Time Count of People Experiencing Homelessness

* There were 3,410 people experiencing literal homelessness on the night of the count this January.
* That is a 13% increase from the prior year count of 3,015 people.
* This includes families with children, individuals, folks staying in shelters, and folks who are staying in places not meant for human habitation.
* For more info, see PIT-2024-Nutmeg-Final-Report_2024.07.30.pdf (ctbos.org)

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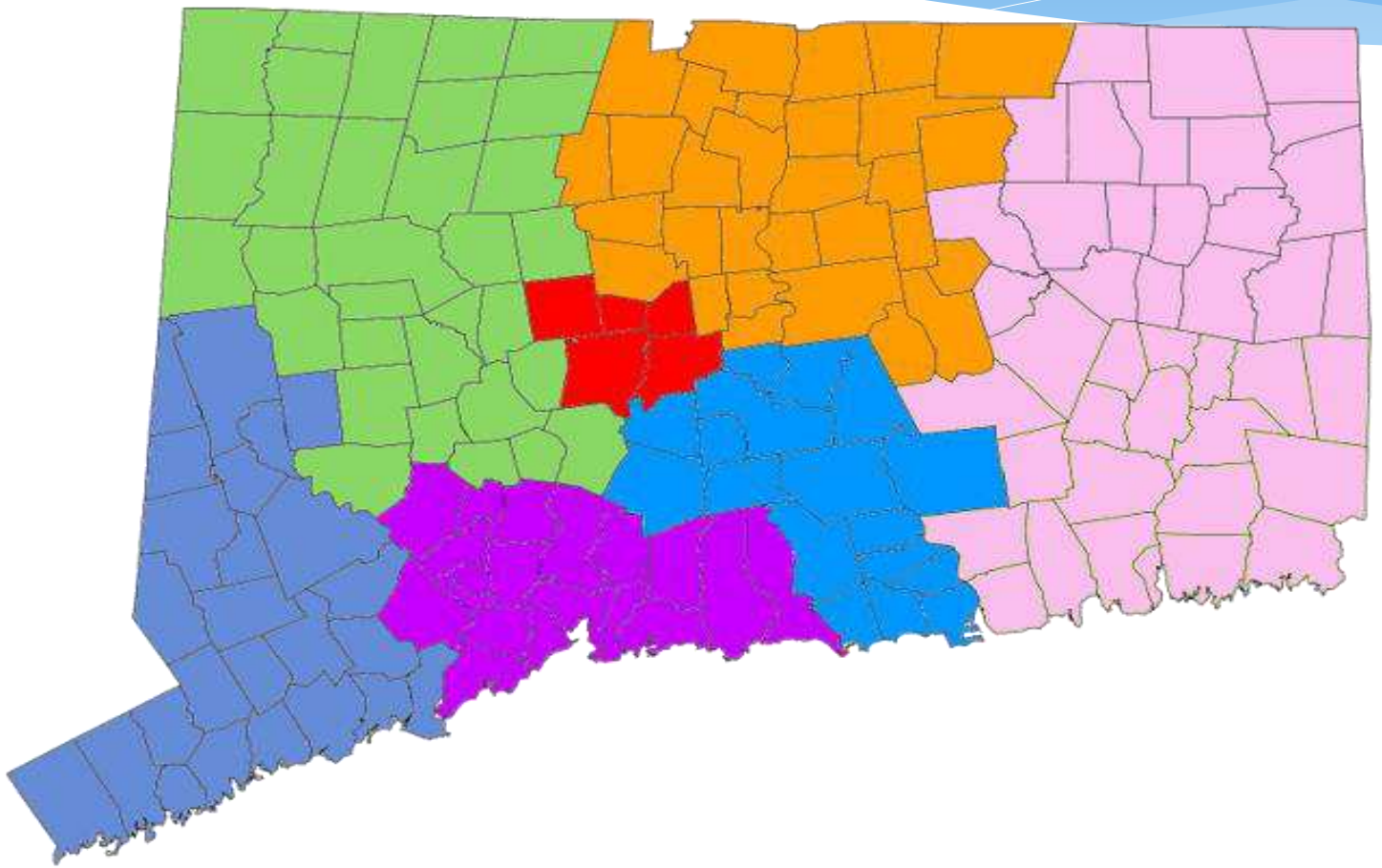
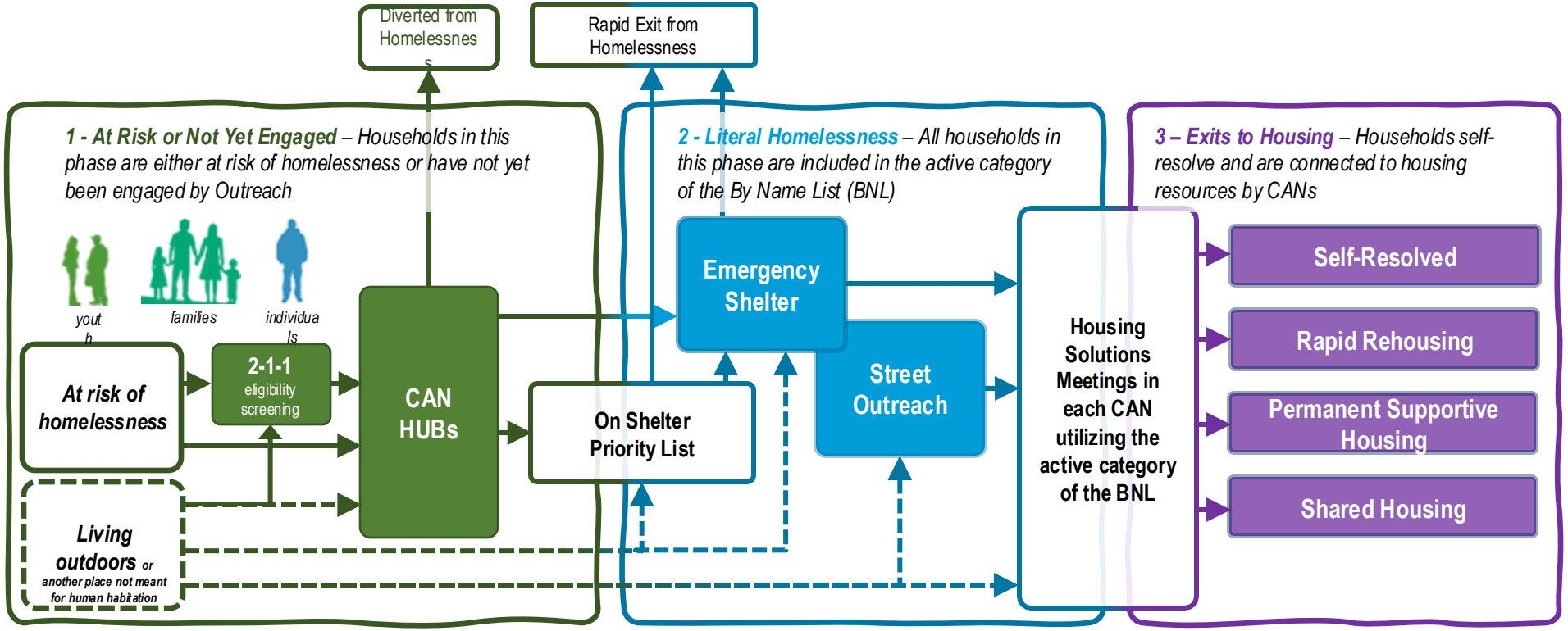
CAN Map



CAN System Overview

A high-level diagram of the coordinated access process from points of entry to points of exit



Services for People Experiencing Homelessness

* Outreach Workers – support folks who are unsheltered in meeting basic needs like food and safety, work towards housing
* Diversion – Financial assistance and mediation to prevent people from entering homelessness
* Shelters – Places for folks to stay while they are experiencing homelessness – most communities operate waitlists for shelter

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Housing Supports

* One Time Assistance/ Rapid Exit – financial assistance like a security deposit or one month's rent to help folks exit homelessness
* Rapid Re-Housing – Time-limited rental support with case management services available
* Supportive Housing – non-time-limited subsidy, where participants contribute 30% of whatever income they have towards rent, and the voucher pays the remaining rent. Case management services are available.

There are dramatically more people experiencing homelessness in CT than there are housing program openings.

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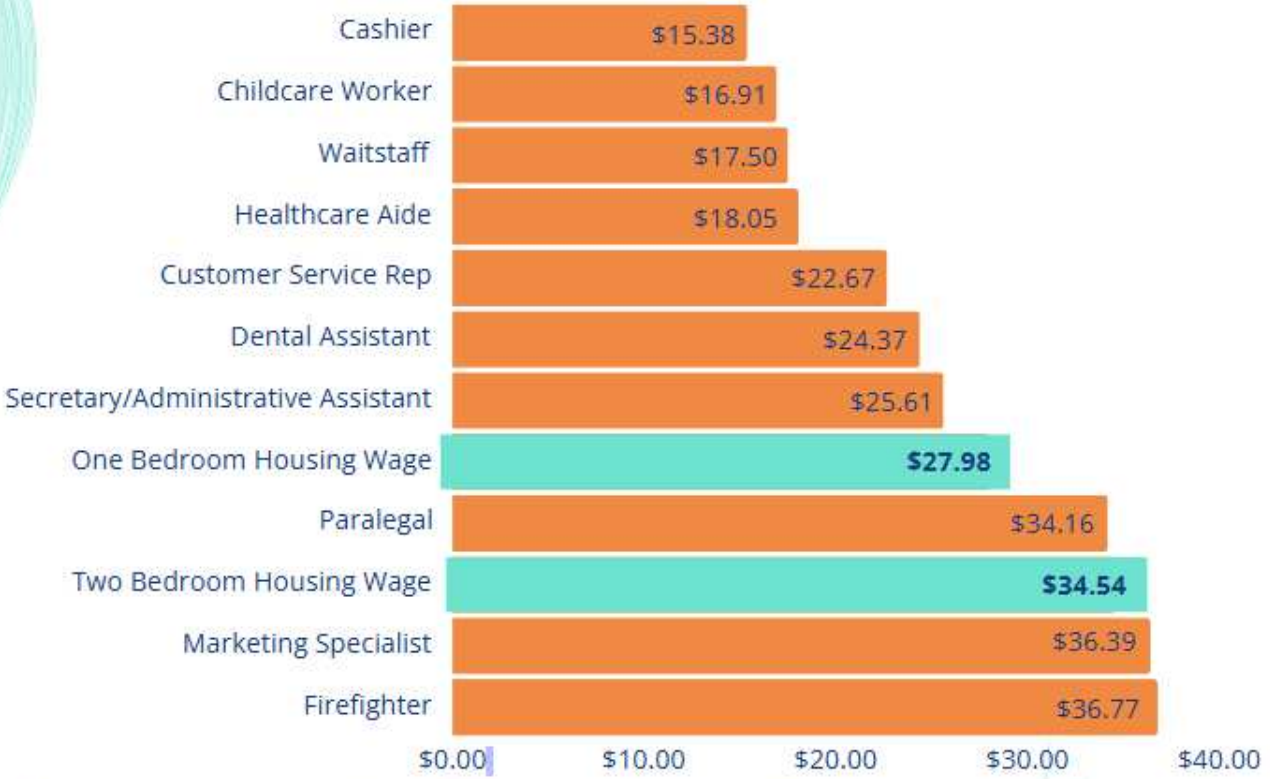
CONNECTICUT'S HOUSING WAGE 2024

THE STRUGGLE TO AFFORD HOUSING

Changes in the economy, household formation, inflation, and wage stagnation leave many in Connecticut struggling to afford housing. Many jobs pay less than what is needed to afford a typical 2-BR apartment (known as the housing wage) at **$34.54/hour**. One third of all Connecticut households rent, and **the average hourly wage of a Connecticut renter, $20.30**, falls below the wage even needed to afford a typical 1-BR apartment at **$27.98/hour**. Over the past year, the **income needed to afford 1- and 2-BR apartments has increased by 8%**, while the **average hourly wage of a Connecticut renter has increased by only $0.01**. To spend no more of 30% of their income on housing, a full-time worker at Connecticut's minimum wage would only be able to afford **an apartment priced at $815/month**.



The housing wage needed for a 2-BR apartment can be significantly higher in more expensive towns, despite wages generally remaining consistent statewide. The top five most expensive metro areas for housing in CT are **Stamford ($50.54), Danbury ($42.71), Bridgeport ($37.83), Milford ($33.88), and New Haven ($32.94)**. Bridgeport saw a 19% increase in the housing wage in a single year, from $31.77 in 2023 to $37.83 in 2024.

For more info, visit:
[Housing Data – Partnership for Strong Communities (pschousing.org)]

Impact of homelessness

* Homelessness is extremely traumatic. The uncertainty of not knowing where you will reside, sometimes where you will eat, who you will interact with, impacts all areas of life.
* The number one predictor of homelessness is a past experience of homelessness. Children who spend time in shelters are more likely to experience homelessness as adults.
* Homelessness is most often a result of all other safety nets failing, so for many people they have already experienced systemic trauma, and ultimately still became homeless.
* People without a home die, on average, 30 years earlier than people with stable housing.

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Encampments

* Approaches that involve criminal penalties cost three times more than providing housing and services and can lead to unintended, harmful, and even deadly consequences.

* Criminalization often leads to encampment sweeps, but clearing an encampment without offering housing and support does not solve homelessness in the short or long term. Instead, it simply moves people experiencing homelessness from block to block and from streets to jails.

How to help

* The best way to help folks in a housing crisis is to try and help prevent homelessness. This can include trying to help mediate with a landlord, seeking out additional income, connecting them to supported employment programs or additional benefits, helping them identify family and friends.

* If people are in need of shelter, help make the initial call to 211. Learn where the Hubs are in your community so you can help make warm handoffs.

Homelessness is Systemic

* People experience homelessness because of many interrelated factors, but it's important to recognize a housing crisis isn't about individual failure.
* Housing costs dramatically outpace minimum wage in CT, and housing stock is extremely limited. The services we have to support people experiencing homelessness have not kept pace with the inflow of people experiencing housing crises.
* Talking to your own community about what is being done to increase housing options is another piece of this puzzle.

Questions?

* Feel free to reach out to mollie.machado@ct.gov 860-941-9451

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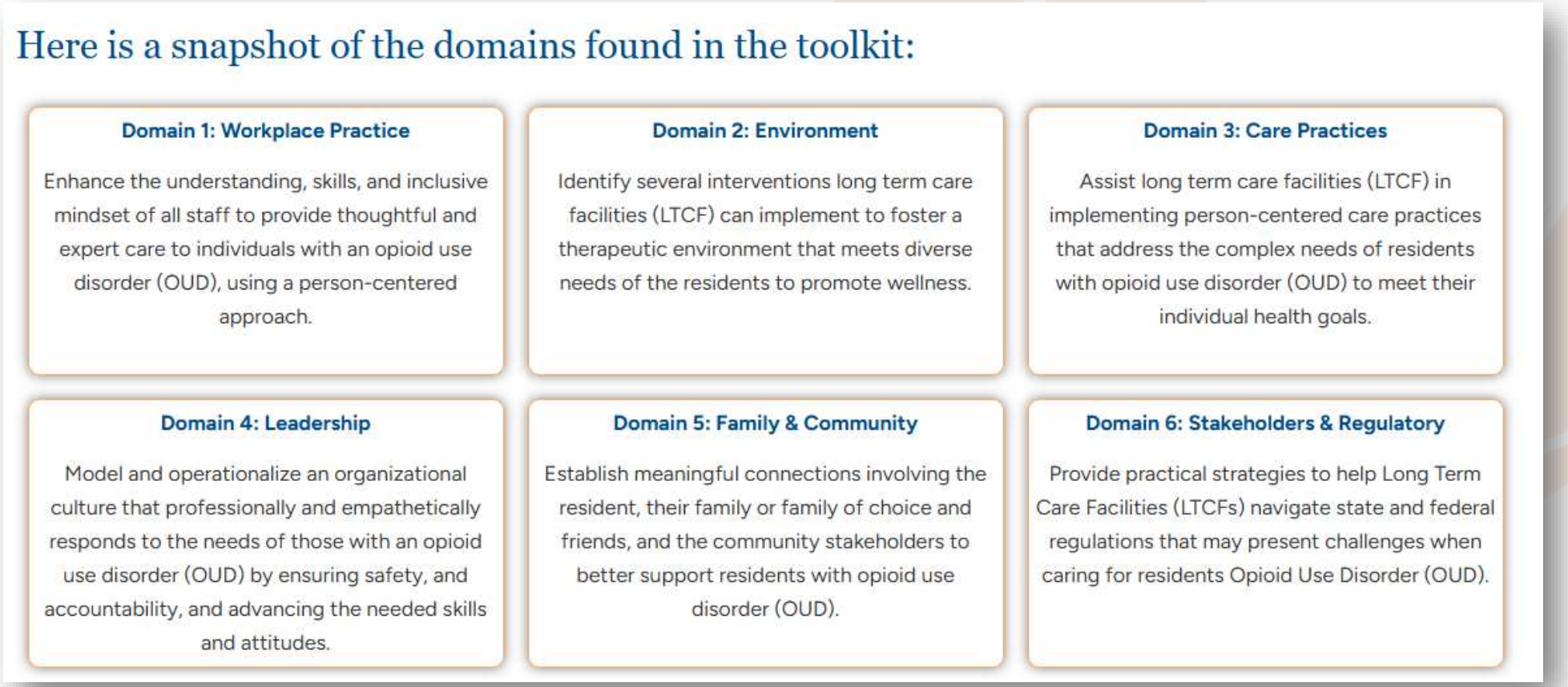
Questions?

Website



Here is a snapshot of the domains found in the toolkit:

Domain 1: Workplace Practice

Enhance the understanding, skills, and inclusive mindset of all staff to provide thoughtful and expert care to individuals with an opioid use disorder (OUD), using a person-centered approach.

Domain 2: Environment

Identify several interventions long term care facilities (LTCF) can implement to foster a therapeutic environment that meets diverse needs of the residents to promote wellness.

Domain 3: Care Practices

Assist long term care facilities (LTCF) in implementing person-centered care practices that address the complex needs of residents with opioid use disorder (OUD) to meet their individual health goals.

Domain 4: Leadership

Model and operationalize an organizational culture that professionally and empathetically responds to the needs of those with an opioid use disorder (OUD) by ensuring safety, and accountability, and advancing the needed skills and attitudes.

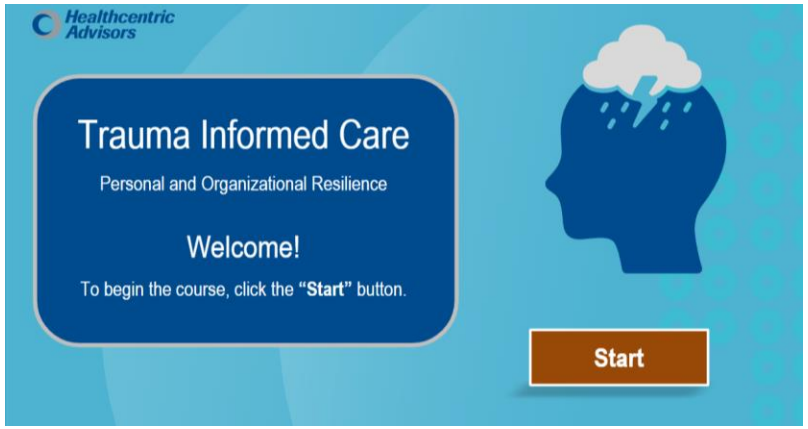
Domain 5: Family & Community

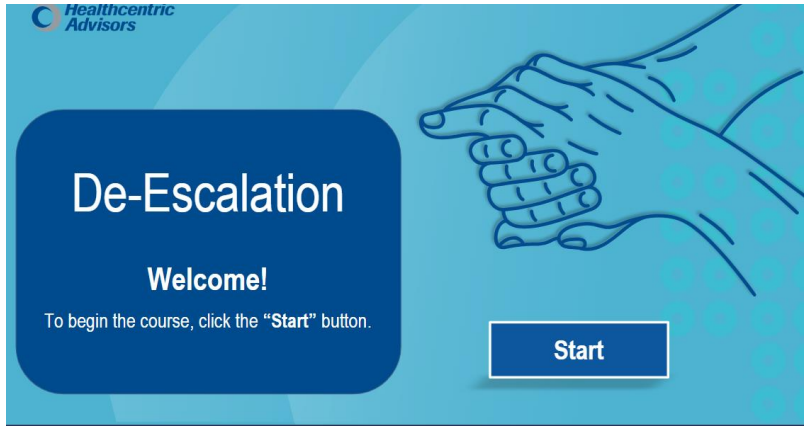
Establish meaningful connections involving the resident, their family or family of choice and friends, and the community stakeholders to better support residents with opioid use disorder (OUD).

Domain 6: Stakeholders & Regulatory

Provide practical strategies to help Long Term Care Facilities (LTCFs) navigate state and federal regulations that may present challenges when caring for residents Opioid Use Disorder (OUD).

https://healthcentricadvisors.org/learning-resources/opioid-use-disorder-in-long-term-care-toolkit/





Companion Education Modules on the LMS

Chat in…

Did this help you learn more about programs that support safe care transitions for long-term care residents with Opioid Use Disorder?

What would you like to learn more about for the next upcoming education session?

Contact Us

sbaker@healthcentricadvisors.org

(401)528-3218

https://healthcentricadvisors.org/learning-resources/opioid-use-disorder-in-long-term-care-toolkit/

Supporting Providers Across New England