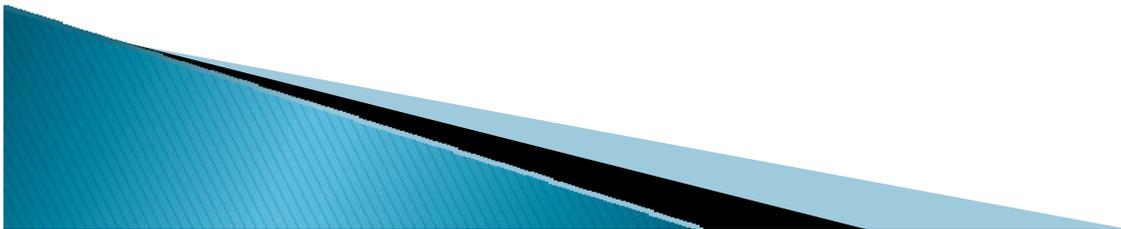


WELCOME

State of Utah PASRR Evaluator Training

October 30, 2019



Today's Presenters

Robert Snarr, MPA, LCMHC, DHS, Division of
Substance Abuse & Mental Health

Erin Lloyd, RN, DOH, Resident Assessment

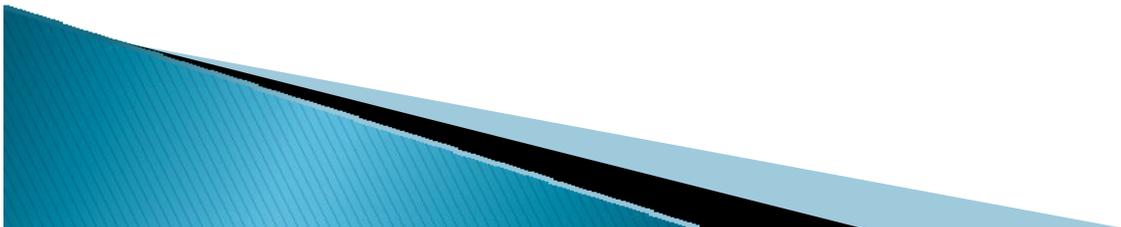
Sheri DeVore, QIDP, ABISC, SSW, Division of Services
for People with Disabilities

Geri Jardine, Division of Substance Abuse & Mental
Health



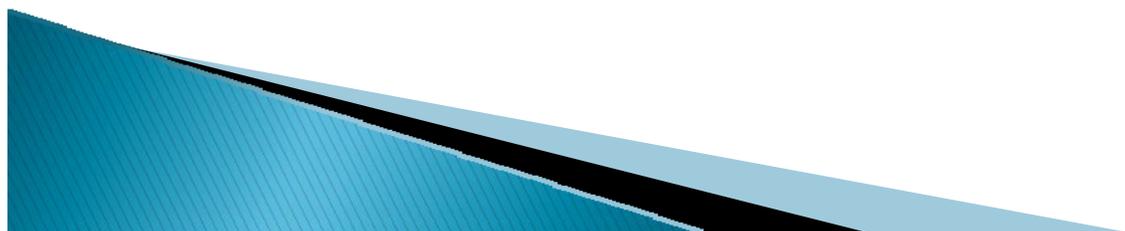
What is PASRR

- ▶ To ensure that individuals are evaluated for evidence of possible mental illness and/or intellectual disabilities and related conditions (ID-RC)
- ▶ To help ensure individuals are placed appropriately, in the least restrictive setting possible
- ▶ To recommend that individuals receive the mental health and/or ID-RC services needed.



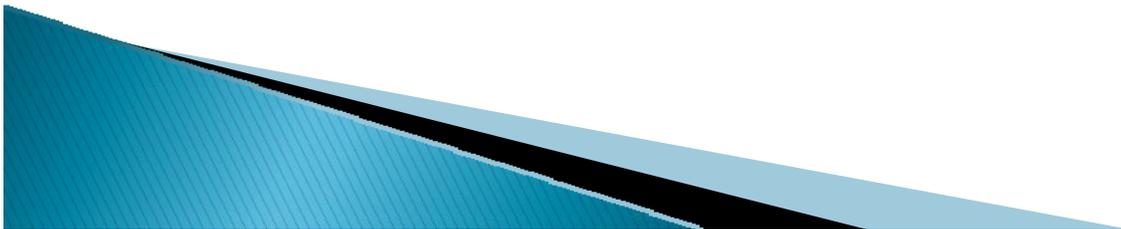
PASRR – The Big Picture

- The goal of PASRR is to ensure all persons with disability are identified, their needs measured, the full array of needed services and supports are detailed in written recommendations, and that recommended services and supports are delivered.
- The goal of PASRR Level I disability screening is to ensure that the power of PASRR evaluations and recommendations are brought to bear for all persons in NFs who have a PASRR disability condition.
- PTAC exists to assist states with everything from high level analysis to working together on nuts and bolts parts of PASRR programs.
- A trend is building for measurement of PASRR quality, outcomes and effectiveness. “Show us the data.”
- Olmstead–“Olmstead v. L.C.” or “the Olmstead decision,”



MDS & Level of Care

- ▶ Medicaid 10A MDS & Level of Care
- ▶ MDS Significant Change
- ▶ Gradual Dose Reduction



R414-502-3. Approval of Level of Care

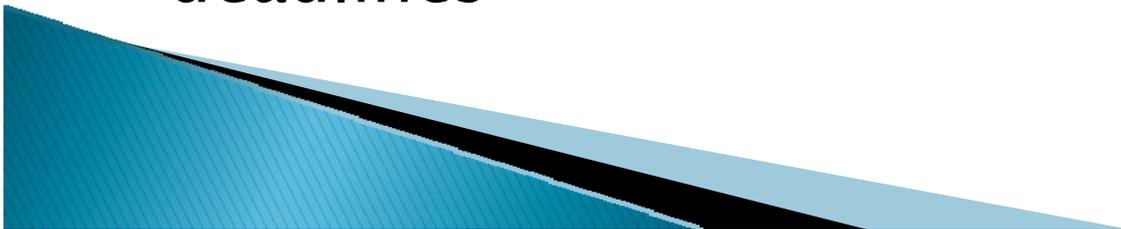
The Department shall document that at least two of the following factors exist ... that require the level of care of a nursing facility or waiver:

- Due to diagnosed medical conditions, the applicant requires **substantial physical assistance** with daily living activities above the level of verbal prompting, supervising, or setting up;
 - The attending physician has determined that the applicant's **level of dysfunction in orientation to person, place, or time requires nursing facility care**; or equivalent care provided through a Medicaid Home and Community- Based Waiver program; or
 - The medical condition and intensity of services indicate that the **care needs of the applicant cannot be safely met in a less structured setting**, or without the services and supports of a Medicaid Home and Community- Based Waiver program.
- 

Medicaid Long Term Care – 10A process

PASRR affects the 10A payment for facilities if:

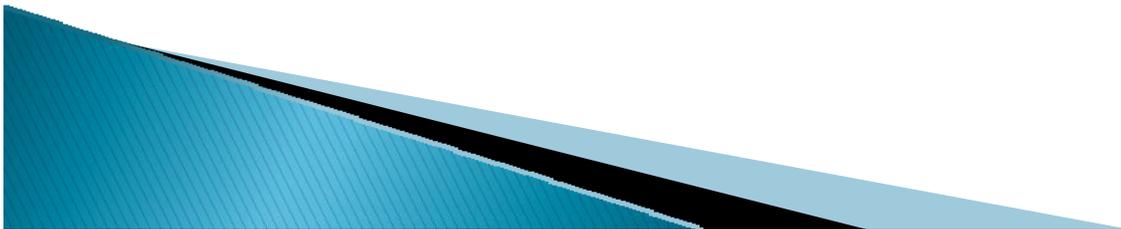
- The Level I is not completed prior to or day of admission
- Less than 30 day stay order is not signed by a physician on the discharge paperwork from a medical hospital stay – acute care hospital only
- Determination is a “denial”
- Facilities fail to appropriately refer for a Level II – missing convalescent/short term stay deadlines



Medicaid Long Term Care – 10A process

Discharge issues:

- Unable to find safe and appropriate placement after residents no longer meet nursing home level of care criteria and are in the facility due to mental illness.
- Potential of working with facilities to recommend placement when PASRR is completed so facilities can work on discharge prior to denial.



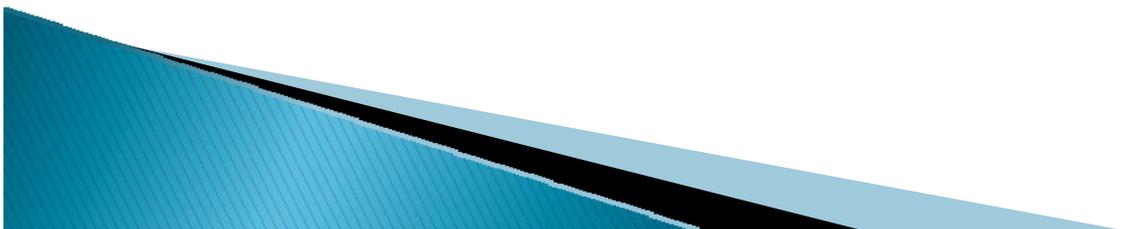
A Significant Change Minimum Data Set (MDS)

A “significant change” is a major decline or improvement in a resident’s status that:

Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered “self-limiting”;

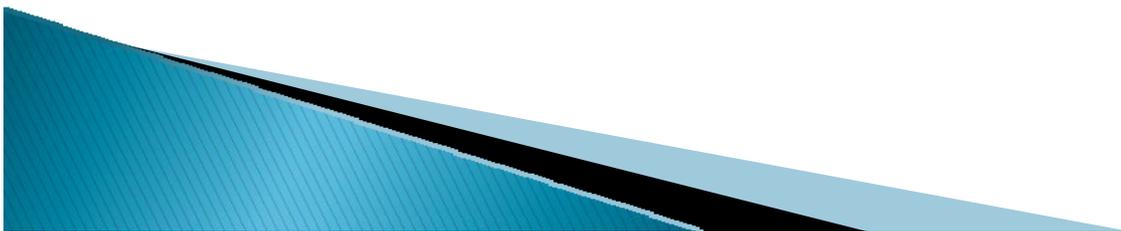
Impacts more than one area of the resident’s health status; and

Requires interdisciplinary review and/or revision of the care plan.



PASRR referral related to a Significant Change MDS

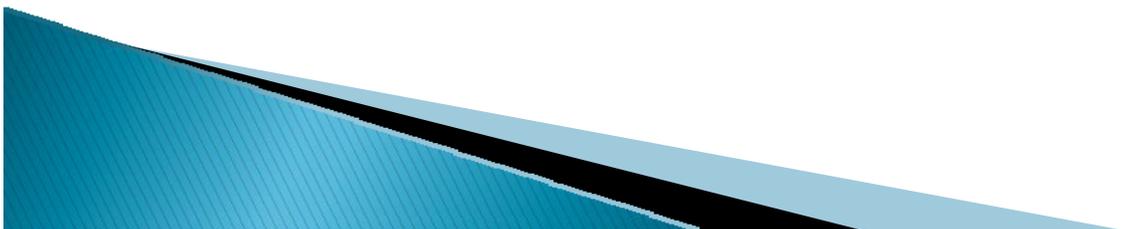
The nursing facility must provide the SMH/ID/DDA authority with referrals ... independent of the findings of the Significant Change MDS. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. **Nursing facilities should have a low threshold for referral to the SMH/ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.**



Reasons for Referral to PASRR for a Significant Change

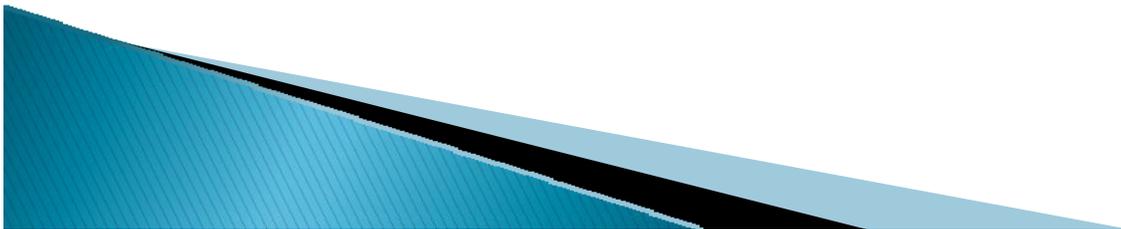
Referral for Level II Resident Review evaluations is required for individuals previously identified by PASRR to have mental illness, intellectual disability/developmental disability, or a related condition in the following circumstances: *Note: this is not an exhaustive list*

- A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.
- A resident with behavioral, psychiatric, or mood related symptoms that have not responded to ongoing treatment.
- A resident who experiences an improved medical condition—such that the resident’s plan of care or placement recommendations may require modifications.
- A resident whose significant change is physical, but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.
- PHQ -9/Mood Assessment score is 19 or above (not dependent on previous PASRR)

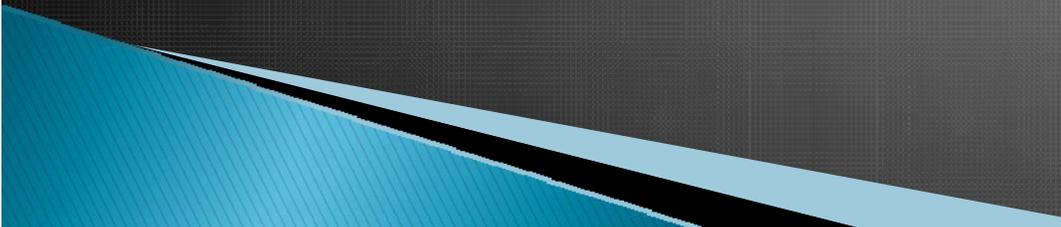


Gradual Dose Reductions

- A gradual dose reduction is defined by the MDS manual as “a step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued”.
- Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating that a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated.

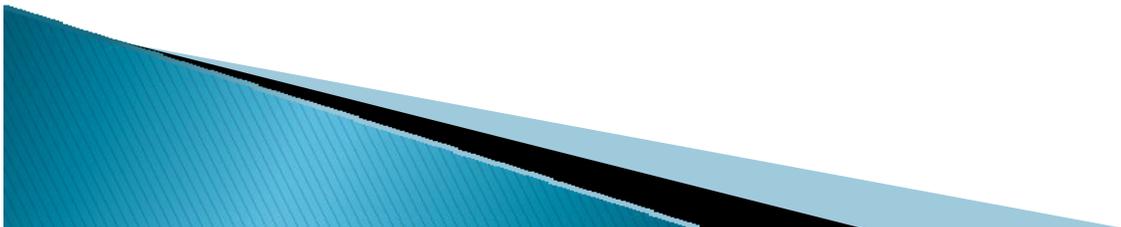


Level I Screening: The Requirements



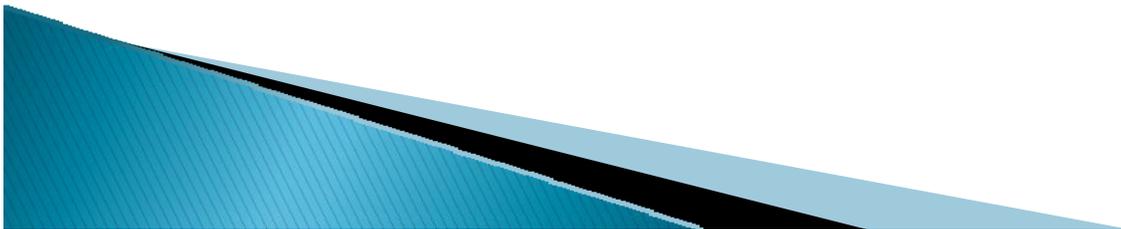
Level I –Identifies:

- ▶ Diagnosis or credible suspicion
- ▶ Intellectual disability
- ▶ Related conditions
- ▶ Serious mental illness
- ▶ Primary Dementia



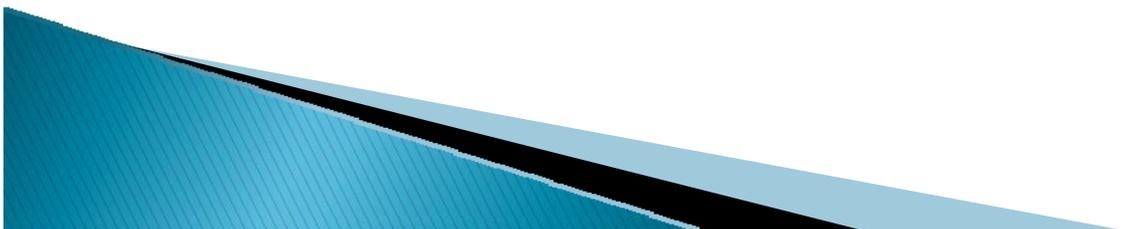
Level I Disability Screen: Purpose

- ▶ To identify all persons who must have the Level II Preadmission Screening (PAS) or Resident Review (RR);
- ▶ That is, to identify all applicants to and residents of Medicaid–certified nursing facilities (NFs) who possibly have serious mental illness, intellectual disability or a related condition.



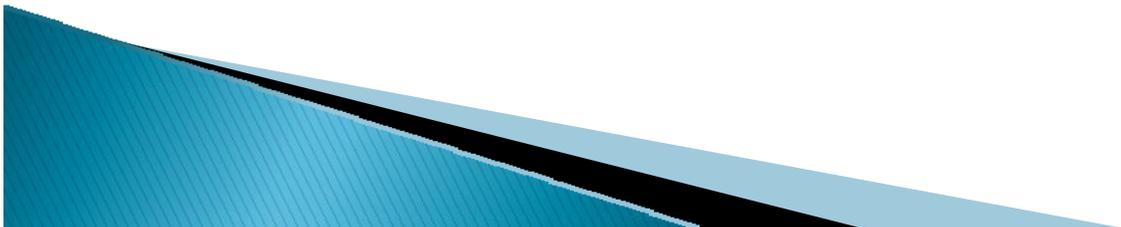
Level I Disability Screen Tasks:

- ▶ Document that evidence is sufficient to rule out all suspicion of PASRR conditions (more than lack of a diagnosis in the record), by documenting on the Level I that the PASRR contractor or IDD Authority or designated entity was contacted, reviewed the collateral and stated that no Level II evaluation was needed.
- ▶ Document that the possible presence of a PASRR condition cannot be ruled out (a Level II evaluation is required),
- ▶ Document when information is sufficient to apply certain predetermined PASRR criteria (hospital exemptions), less than 30 day stay certified in writing by the attending physician.



Structure/Infrastructure Considerations

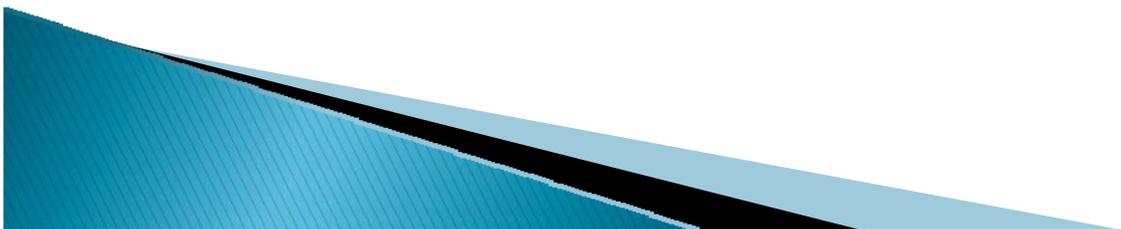
- Integration of Level I with Level of Care
- Integration of Level I screening information with Level II evaluation information (Level II evaluation & State Determination)
- Timeframes



Dementia and NSMI

What is a Primary diagnosis of Dementia?

- PASRR regulations at 42 CFR 483.128(m) permit Level II evaluations to be terminated if the Level II evaluator finds that individual has:
- A primary diagnosis of dementia (including Alzheimer's Disease or a related disorder)" (42 CFR 483.128(m)(2)(i));
- However, an evaluation should not be halted if a PASRR disability has not yet been ruled out.



Level II Form



**PREADMISSION SCREENING RESIDENT REVIEW
PASRR LEVEL II**

UTAH DIVISION OF SUBSTANCE ABUSE
AND MENTAL HEALTH
195 N 1950 W
SALT LAKE CITY, UT 84116

SECTION 1: DEMOGRAPHIC AND ASSESSMENT INFORMATION

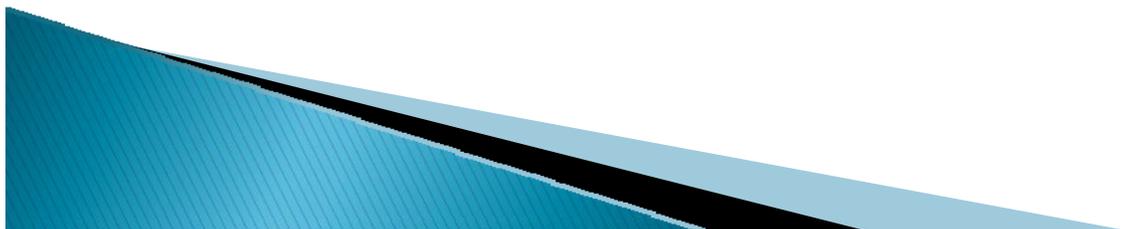
NAME (LAST, FIRST, MIDDLE)			LEVEL I DOCUMENT #
[REDACTED]			[REDACTED]
SOCIAL SECURITY (LAST FOUR DIGITS)	BIRTH DATE (MM/DD/YYYY)	AGE	GENDER
[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/> Female <input type="checkbox"/> Male
RACE			ETHNICITY
<input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander			<input type="checkbox"/> Hispanic
TYPE OF EVALUATION		TYPE OF RE-EVALUATION	
<input type="checkbox"/> Pre-Admission <input type="checkbox"/> Initial <input type="checkbox"/> End of Provisional Stay <input type="checkbox"/> Over 30 Day MD Certified Stay <input type="checkbox"/> End of Respite		<input type="checkbox"/> End of Convalescent Care Stay <input type="checkbox"/> End of Short Stay <input type="checkbox"/> Significant Change <input type="checkbox"/> Assessment Update	

SECTION 1.1: REFERRAL INFORMATION/SCREENING LOCATION

REFERRAL DATE	ASSESSMENT START DATE	DATE MEDICAL/PHYSICAL INFO AVAILABLE (LEVEL I, H&P AND MD ORDER)		
[REDACTED]	[REDACTED]	[REDACTED]	MDS attached: <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOSPITAL ADMISSION?	NAME OF HOSPITAL	ADMIT DATE	DISCHARGE DATE	ER ONLY
<input type="checkbox"/> YES <input type="checkbox"/> NO	[REDACTED]	[REDACTED]	[REDACTED]	<input type="checkbox"/> YES <input type="checkbox"/> NO
REFERRING AGENCY IF NOT HOSPITAL	ADMIT DATE IF IN NF	NAME OF REFERRAL SOURCE	PHONE NUMBER	
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

SECTION 1.2: LEGAL STATUS

<input type="checkbox"/> Self	<input type="checkbox"/> Legal Guardian/Conservator	POWER OF ATTORNEY		PHONE #
<input type="checkbox"/> Commitment	<input type="checkbox"/> Legal Representative/POA	[REDACTED]		[REDACTED]
LEGAL GUARDIAN NAME			PHONE #	CELL PHONE
[REDACTED]			[REDACTED]	[REDACTED]
LEGAL GUARDIAN ADDRESS				
[REDACTED]				
APPLICANT/RESIDENT AGREES TO LEGAL GUARDIAN/REP. AND/OR FAMILY PARTICIPATION		TRANSLATOR REQUIRED (IF YES, PLEASE PROVIDE TRANSLATOR NAME AND LANGUAGE)		
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	Name: [REDACTED]	Language: [REDACTED]



SECTION 2: MEDICAL JUSTIFICATION & INTENSITY OF SERVICES NEEDED IN NURSING FACILITY

Diagnosis	Onset Date	Diagnosis	Onset Date
█	█	█	█
█	█	█	█
█			

Include height and weight if obesity is a factor: Height: █ Weight: █ BMI: █

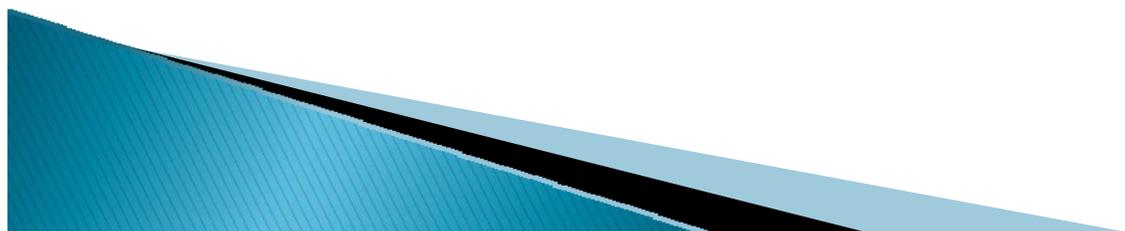
SECTION 3: MENTAL HEALTH SYMPTOMS/SUBSTANCE USE SUMMARY

Onset of Psychiatric Symptoms with a Medical Condition: Describe medical conditions that may be contributing to the onset of psychiatric symptoms, including date of onset of the medical condition.

History/Onset Of Psychiatric Symptoms: Describe when symptoms started and if there was a precipitating event or circumstance. Also, describe how these specific Psychiatric diagnosis and related symptoms have resulted in serious difficulty in functional limitations in major life activities.

Substance Use History: █

Current Psychiatric Functioning: General summary of current functioning, document supportive services required due to SMI in reference to Sec 4 - 483.102(iii)(A)(B). For eg: "Supportive Services" include home health, case management, assistance with self-care and/or other supports.



Section 3.1: DIAGNOSTIC SPECIFIC CHECKLISTS

For all psychiatric diagnoses, there must be a history of functional impairment. Sufficient symptoms to meet the criteria must have been present in the past or currently. Symptoms must have been present in the ABSENCE of substance abuse, and must PRE-DATE medical diagnoses that have psychiatric symptoms as a physiological consequence. = Current/Past

AFFECTIVE DISORDERS

Major Depressive Episode/Disorder (must meet 1. or 2. AND 4 additional for the past 2 weeks)

- Depressed Mood
- Anhedonia
- Weight change: Loss or Gain
- Sleep: Insomnia or Hypersomnia
- Psychomotor: Retardation or Agitation
- Fatigue/Loss of Energy
- Worthlessness or Inappropriate Guilt
- Concentration Impairment
- Thoughts of Death or Suicidal ideation or Suicide attempt

Manic Episode/Hypomanic Episode

A period of elevated, expansive, or irritable mood AND persistently increased goal-directed activity or energy lasting at least one week for a manic episode and at least 4 days for a hypomanic episode and present most of the day nearly every day. AND -

Three or more of the following (4 if mood is only irritable):

- Grandiosity/inflated self-esteem
- Decreased need for sleep
- Pressured speech
- Racing thoughts/Flight of ideas
- Distractibility
- Increased goal-related activity or psychomotor agitation
- Increased risk-taking

Bipolar I Disorder

- Criteria have been met for at least one manic episode
- The symptoms are not better explained by another psychotic disorder (schizoaffective disorder, schizophrenia, etc.)

Bipolar II Disorder

- Criteria have been met for at least one hypomanic episode
- Criteria have been met for a Major Depressive episode

PSYCHOTIC DISORDERS

Schizophrenia (1, 2, or 3 below plus one additional)

- Delusions 2. Hallucinations 3. Disorganized speech
- Negative symptoms (i.e. diminished emotional expression)
- Grossly disorganized or catatonic behavior.

AND

- Significant decrease in level of functioning since onset AND
- Continuous signs of the disorder for at least 6 months

Schizoaffective Disorder

- Schizophrenia and a major mood episode occur concurrently AND
- Delusions or hallucinations in the absence of mood symptoms at some point during the illness AND
- Major mood symptoms are present the majority of the time

Delusional Disorder

- The presence of one or more delusions for at least one month
- Schizophrenia criteria have never been met
- Apart from the delusion(s), functioning is not very impaired
- If Mania or MDD have occurred, they have been brief relative to the duration of the delusion(s)

Psychotic Disorder NOS

- Symptoms characteristic of schizophrenia or another psychotic disorder are present that cause clinically significant distress or impairment in major life functioning but do not meet the full criteria for any disorder.

ANXIETY DISORDERS

Generalized Anxiety Disorder (must meet first 2 criteria and 3 of the remaining 6 for at least 6 months)

- Excessive worry about many things for at least 6 months AND
- Difficulty controlling the worry

- Restlessness
- Easily Fatigued
- Concentration difficulty/mind going blank
- Irritability
- Muscle Tension
- Sleep impairment (initiation, staying asleep)

Panic Disorder (must meet first criteria and 4 of the remaining)

- Abrupt surge of intense fear, peaking within minutes AND
- Increased heart rate Derealization/Depersonalization
- Trembling/Shaking Shortness of breath/Smothering
- Choking sensation Chest discomfort
- Abdominal distress Light-headed/dizzy/unsteady
- Sweating Fear of losing control/going crazy
- Fear of dying Numbness/Tingling
- Chills or hot flushes

At least one attack has been followed by one month of either:

- Excessive worry about having another panic attack OR-
- A maladaptive change in behavior (i.e. to avoid further attacks)

Agoraphobia

Marked fear or anxiety about 2 or more of the following:

- Using public transportation Being in enclosed spaces
- Being in open spaces Being outside of the home alone
- Standing in line or being in a crowd

AND -

- Avoidance of such situations because escape might be difficult,
- The situations almost always provoke fear/anxiety, AND
- The situations are actively avoided, require the presence of a companion, or are endured with intense fear/anxiety.

Posttraumatic Stress Disorder

Exposure to a life-threatening event to self or significant other AND - Intrusion - presence of one or more of the following symptoms:

- Recurrent, involuntary, and intrusive distressing memories
- Recurrent distressing dreams related to the event
- Dissociative reactions (e.g. flashbacks)
- Intense or prolonged distress at exposure OR
- Marked physiological reactions to cues that symbolize or resemble the event AND -

Avoidance of Trauma Associations (must meet 1 or more)

- Internal: Thoughts, feelings, memories
- External: Activities, places, people, situations AND -

Negative mood/cognitions as evidenced by 2 or more of the following:

- Inability to recall aspects of the event (not due to TBI)
- Negative beliefs/expectations about self/others
- Inappropriate blaming of self or others for the event
- Persistent negative emotional state (fear, anger, guilt, shame)
- Diminished interest in significant activities
- Feelings of detachment or estrangement from others
- Persistent inability to experience positive emotions AND -

Increased arousal/reactivity as evidenced by 2 or more:

- Irritability/anger with little or no provocation
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

AND -

- Duration of disturbance is greater than one month

PERSONALITY DISORDERS - Below is a summary of all personality disorders. If an individual's presentation is consistent with the description, the evaluator should review the specific DSM V diagnostic criteria for the disorder to determine whether diagnostic criteria are met. In all instances, the described symptoms are severe, pervasive, have been present since early adulthood, and are seen in a variety of contexts/situations

Cluster A:

Paranoid Personality – Distrust and suspiciousness of other such that their motives are interpreted as malevolent.

Schizoid Personality – Detachment from social relationships and a restricted range of expression of emotions in interpersonal settings.

Schizotypal Personality – Social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships and by cognitive or perceptual distortions and behavioral oddities.

Cluster B:

Antisocial Personality – Disregard for and violation of the rights of others, beginning by age 15.

Borderline Personality – Instability of interpersonal relationships, self-image, and affect as well as marked impulsivity.

Histrionic Personality – Excessive emotionality & attention seeking.

Narcissistic Personality – Grandiosity (in fantasy or behavior), an excessive need for admiration, and a marked lack of empathy.

Cluster C:

Avoidant Personality – Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

Dependent Personality – Excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation.

Obsessive-Compulsive Personality – Preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness, and efficiency.

ANXIETY DISORDERS (cont.)

Obsessive Compulsive Disorder (must meet 1. or 2. AND 3. or 4.

1. Obsessions – intrusive thoughts, urges, images that cause marked distress, with an attempt to ignore or suppress with another thought or a compulsion OR
2. Compulsions –repetitive behavior driven to perform due to an obsession or a set of rigid rules, to reduce anxiety, are not realistically connected to the obsession or are clearly excessive.
3. Time consuming –more than one hour a day OR
4. Cause clinically significant distress/impairment

Somatization Disorder (must meet first criteria and 2 additional)

Presence of one or more very distressing somatic symptoms that cannot be fully explained by a general medical condition AND

1. Disproportionate and persistent thoughts about the symptom
2. Persistently high level of anxiety about health or symptom(s)
3. Excessive time and energy devoted to the symptom(s)

AND

Duration of symptoms is 6 months or more.

ALL DIAGNOSES GIVEN MUST MEET DSM V CRITERIA.

SECTION 4: LEVEL OF IMPAIRMENT (ADAPTED FROM CFR 483.102(II)(A)(B)(C))

Functional limitations in major life activities within the past 3 to 6 months. Must have at **least one** of the following characteristics on a **continuing or intermittent** basis in each area - Adaptation to Change, Concentration and Interpersonal Functioning.

Adaptation to change (serious difficulty)

- Adapting to typical changes in circumstances associated with: Family School Social Interaction Work
- Exacerbated signs and symptoms associated with the illness
- Manifests agitation
- Requires intervention of the mental health or judicial system
- Withdrawal from the situation

Concentration, Persistence and Pace (serious difficulty)

- Difficulties in concentration
- Inability to complete simple tasks within an established time period
- Makes frequent errors
- Requires assistance in completion of these tasks
- Sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work setting or work-like structured activities occurring in school or home settings

Interpersonal Functioning (serious difficulty)

- | | |
|--|---|
| <input type="checkbox"/> Maintaining interpersonal relationships | <input type="checkbox"/> Employment |
| <input type="checkbox"/> Communicating effectively with others | <input type="checkbox"/> Criminal Justice Involvement |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Social Isolation |
| <input type="checkbox"/> Fear of strangers | <input type="checkbox"/> Violence |

483.102(iii)(A)(B) Recent Treatment

- Psychiatric treatment more intensive than outpatient care **more than once** in the past 2 years: (e.g., partial hospitalization/day treatment or in-patient hospitalization; crisis intervention) **OR**

Within the last 2 years:

- Experienced an episode of significant disruption to the normal living situation which:
 - Required supportive services **due to serious mental illness**, to maintain function at home or in a residential treatment environment **OR**
 - Resulted in intervention by housing or law enforcement officials

SECTION 5.0 MENTAL STATUS EXAMINATION/SUMMARY					
SECTION 5.1 DESCRIPTION					
Appearance: <input type="checkbox"/>					
Attitude: <input type="checkbox"/>					
Overt Behavior: <input type="checkbox"/>					
Affect: <input type="checkbox"/>					
Thought Form & Content: (i.e. linear, logical, tangential): <input type="checkbox"/>					
Speech Clarity & Modes of Expression: <input type="checkbox"/>					
SECTION 5.2: EVALUATION OF COGNITIVE FUNCTIONING					
ORIENTATION: (Y)es, (P)artial, (N)o, (U)nable to assess		<input type="checkbox"/> - Person	<input type="checkbox"/> - Place	<input type="checkbox"/> - Situation	<input type="checkbox"/> - Time
CONSCIOUSNESS:		<input type="checkbox"/> - Alert	<input type="checkbox"/> - Drowsy	<input type="checkbox"/> - Delirious	<input type="checkbox"/> - Comatose
JUDGMENT:	Independent <input type="checkbox"/>	Modified Independence <input type="checkbox"/>	Moderately Impaired <input type="checkbox"/>	Severely Impaired <input type="checkbox"/>	
MEMORY:	RECENT:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Intact	<input type="checkbox"/> Unable to assess
	REMOTE:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Intact	<input type="checkbox"/> Unable to assess
INSIGHT (Knowledge of Illness)		<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Intact	<input type="checkbox"/> Unable to assess
Additional Testing Results (if available): (i.e. mental status exam, depression inventory. Attach copy.) <input type="checkbox"/>					
Would the Applicant/Resident benefit from referral for guardianship/conservatorship services? <input type="checkbox"/> YES <input type="checkbox"/> NO					
SECTION 5.3: ASSESSMENT FOR DANGER TO SELF OR OTHERS					
Do your findings indicate the Applicant/Resident may be a substantial danger to himself/herself or others? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, does the nursing facility's supervision and structure mitigate the danger? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: <input type="checkbox"/>					
SECTION 5.4: INTELLECTUAL DISABILITY-RELATED CONDITION					
Does the Applicant/Resident have a documented history of intellectual disability? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the Applicant/Resident have a documented history of a related condition? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes to either question, what is the diagnosis? <input type="checkbox"/>					

SECTION 6: CURRENT MEDICATIONS - Psychiatric medications taken within the last 30 days that could mask or mimic symptoms of mental illness:			
MEDICATION	DOSE/FREQUENCY	MEDICATION	DOSE/FREQUENCY
█	█	█	█
█	█	█	█
█	█	█	█
█	█	█	█

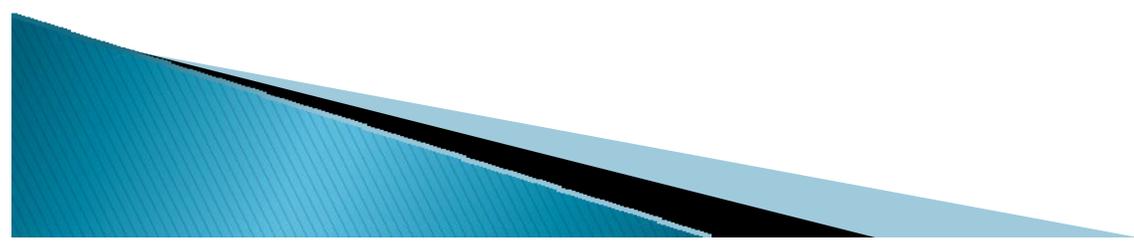
Allergies/Adverse Reactions/Side Effects: █

SECTION 7: MENTAL HEALTH/SUBSTANCE ABUSE DIAGNOSTIC SUMMARY IMPRESSION			
DSM-V	Diagnosis Description	DSM-V	Diagnosis Description
█	█	█	█
█	█	█	█
█	█	█	█

Diagnostic Formulation: █

Recommendations for services to be provided by the Nursing Facility: █

Recommendation for Specialized Services for mental health treatment: █



SECTION 8: REVIEW OF RECOMMENDATIONS

SECTION 8.1: RECOMMENDATIONS FOR CATEGORICAL DETERMINATIONS

Check one:

Convalescent Care Stay Short Stay Severe Physical Illness Terminal Illness

SECTION 8.2: RECOMMENDATIONS FOR NSMI/DENIAL DETERMINATIONS

Not Seriously Mentally Ill (NSMI) for purposes of PASRR

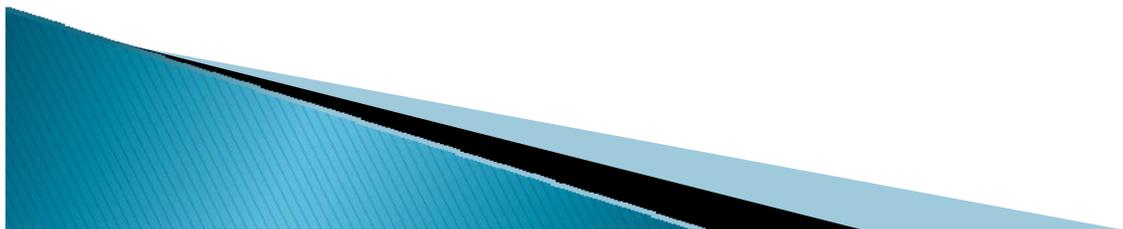
Denial due to the need for acute psychiatric treatment with a medical need that requires NF services

Denial due to the need for acute psychiatric treatment with no medical need

Denial due to a lack of medical need and no need for acute psychiatric treatment – (Complete Sections 9 through 15 if using this determination.)

For all Denial recommendations: Inform the Nursing Facility and the State PASRR office (pasrradmin@utah.gov) no later than the day the evaluation is submitted to the online PASRR system.

For Long Term Care, Severe Physical Illness, Terminal Illness, and Denial due to a lack of medical need and no need for acute psychiatric treatment, complete Sections 9 through 15. For all other recommendations: STOP ASSESSMENT HERE, skip to Section 15, complete the Nursing Facility Levels of Care, and sign the evaluation.



SECTION 9: PSYCHOSOCIAL EVALUATION/SUMMARY

SECTION 9.1: Applicant/Resident's place of residence prior to hospital or nursing facility placement. Include social history (developmental, educational, special education, occupational, marital and social supports)

SECTION 9.2: PSYCHOSOCIAL STRENGTHS

SECTION 9.3: PSYCHOSOCIAL NEEDS (identify recommendations)

SECTION 10: APPLICANT/RESIDENT'S ACTIVITIES OF DAILY LIVING FUNCTIONAL ASSESSMENT

ACTIVITIES	N/A	SELF INITIATES ADL TASKS INDEPENDENTLY	SUPERVISION, OVERSIGHT, ENCOURAGEMENT OR CUEING	LIMITED ASSISTANCE RECEIVES PHYSICAL HELP (RESIDENT INVOLVED)	EXTENSIVE ASSISTANCE RESIDENT PERFORMED PART OF ACTIVITY	TOTAL DEPENDENCE COMPLETE NON-PARTICIPATION
1. Toilet Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Bladder Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Bowel Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Locomotion - On unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Off Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. <input type="checkbox"/> Wheelchair/ <input type="checkbox"/> Walker/ <input type="checkbox"/> Cane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Bed Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Verbal/Gestural or Written Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Self-Monitoring of Health Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Self-Administration of Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Medication Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Self-Directive Accessing Medical Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Eating & Monitoring of Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Bathing-Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Dressing Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Handling Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Source of Information: <input type="checkbox"/>						

SECTION 11: NURSING FACILITY SERVICES

Identify the specific nursing facility services that the Applicant/Resident requires for nursing facility placement. Check all that apply.

<input type="checkbox"/> Assistance with ADL's	<input type="checkbox"/> IV Antibiotics	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Colostomy Care
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Feeding Tube	<input type="checkbox"/> Wound Care	<input type="checkbox"/> Monitor Safety (i.e. falls, wandering risk)
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Monitor Diet	<input type="checkbox"/> Skin Care	<input type="checkbox"/> Total Care for ADL's
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Monitor Medications	<input type="checkbox"/> Catheter Care	<input type="checkbox"/> Other _____

SECTION 12: DISCHARGE POTENTIAL AND PROGNOSIS FOR NON-INSTIUTIONAL LIVING ARRANGEMENTS

Poor Fair Good Excellent

Could Applicant/Resident currently reside in a less restrictive community-based setting? YES NO
Is the Applicant/Resident in agreement with nursing facility placement? YES NO
If no, is the Applicant/Resident medically capable of residing in a non-institutional setting? YES NO

SECTION 13: TYPE OF SUPPORTS THAT MAY BE NEEDED TO PERFORM ACTIVITIES IN THE COMMUNITY

If the applicant/resident's medical condition stabilizes, identify the supports that will be needed to perform activities of daily living in the community. Include recommendations & alternative placement options: _____

SECTION 14: NURSING FACILITY SERVICES RECOMMENDATION

NURSING FACILITY SERVICES (LTC)- This is the Long Term Care determination option for those who will require more than 120 days of nursing facility care.

SECTION 15: PASRR LEVEL II NURSING FACILITY LEVELS OF CARE

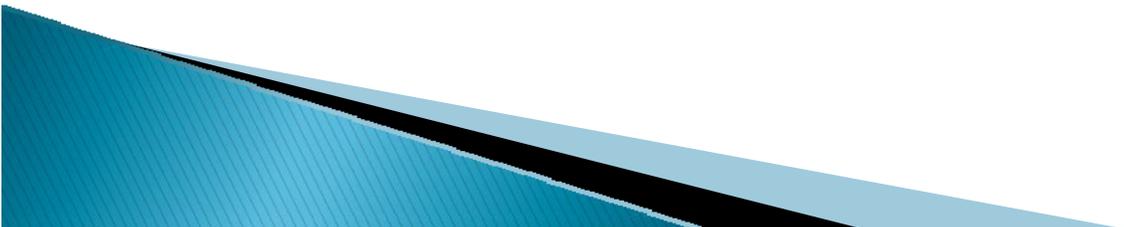
Criteria for Level of Nursing Service for Applicant/Resident with a **SERIOUS MENTAL ILLNESS** as defined by the State Mental Health Authority. The request for nursing facility services must document that the applicant/resident has **TWO or MORE** of the following elements according to Administrative Rule R414-502:

<input type="checkbox"/>	Due to diagnosed medical conditions, the Applicant/Resident requires at least substantial physical assistance with activities of daily living about the level of verbal promptings, supervising, or setting up;
<input type="checkbox"/>	The attending physician has determined that the Applicant/Resident's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through an alternative Medicaid health care delivery program (Documentation must be provided to substantiate significant cognitive deficits);
<input type="checkbox"/>	The medical condition and intensity of services indicate that the care needs of the Applicant/Resident cannot be safely met in a less structured setting or without the services and support of an alternative Medicaid health care delivery program (Justification is provided that less structured alternatives have been explored and why alternatives are not feasible).

SECTION 16: SIGNATURE

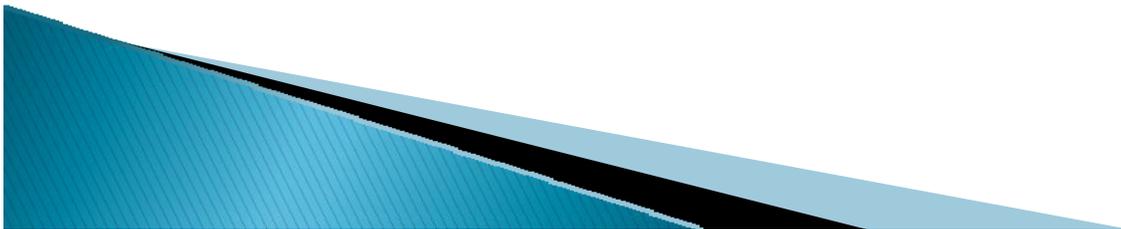
Completed by: <input type="text"/>	License: <input type="text"/>	PASRR Contractor: <input type="text"/>
Evaluator Signature: <input type="text"/>		Date: <input type="text"/>

Revised 01/23/2018

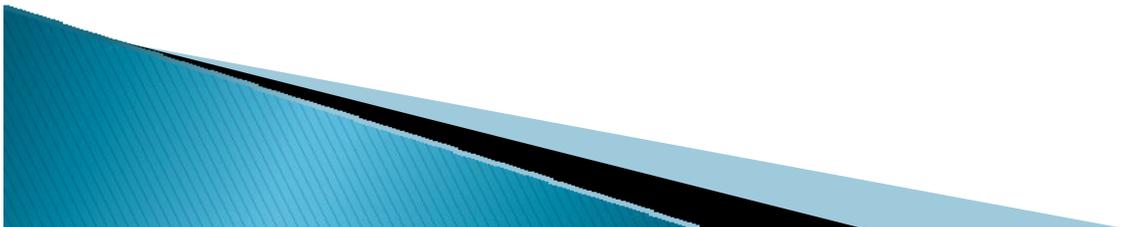


PASRR:
REAL STORIES, REAL PEOPLE

PASRR is thinking about *quality* of
life for persons with disability



QUESTIONS



HOUSEKEEPING

1. When to do an End of Stay vs. Significant Change
 2. Older Adults Conference – Save the Date June 29-30th
 3. Completed Level I – Okay to send back and ask it be completed. Use the referral date of the **completed Level I** as the referral date
 4. Importance of accurate demographic information
 5. Check for Medicaid numbers
 6. How to Resubmit a Level II
- 

Intellectual Disability and Related Condition



PASRR

Intellectual Disability Defined

- An IQ of 70 or less
- Plus, substantial functional limitation in three or more of the following areas of major life activity:

• Self-Care	• Learning
• Expressive/ Receptive Language	• Mobility
• Self-Direction	• Capacity for Independent Living
• Economic Self-Sufficiency	

- Onset during developmental period (prior to 18 years of age)

Related Condition Defined

Medical conditions associated with developmental delay include, but are not limited to:

- Down Syndrome
- Autism Spectrum Disorder
- Fetal Alcohol Syndrome
- Cerebral Palsy
- Epilepsy/Seizure Disorder
- Fragile-X Syndrome
- Prader-Willi Syndrome
- Spina Bifida
- Angelman Syndrome
- Traumatic Brain Injury

Plus, substantial functional limitation in three or more of the areas of major life activity.

Onset during developmental period (prior to 22 years of age)

PREADMISSION SCREENING APPLICANT/RESIDENT REVIEW Revised 1/3/2017
 IDENTIFICATION (ID) SCREENING
 DOCUMENT NUMBER: SAMPLE

SECTION 1

1.1 SCREENING DATE (MM/DD/YYYY)	/ /
------------------------------------	-----

Applicant/Resident's Information

1.2 NAME (LAST, FIRST, MIDDLE)	1.3 LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER XXX-XX-	1.4 DATE OF BIRTH (MM/DD/YYYY) / /
1.5 PLACEMENT PRIOR TO REQUEST FOR NURSING FACILITY PLACEMENT:		

Nursing Facility Information

1.7 NURSING FACILITY NAME:	1.8 NURSING FACILITY ADMISSION DATE: (MM/DD/YYYY) / /
----------------------------	--

SECTION 2

2.1 CURRENT MEDICAL DIAGNOSIS

ICD-Codes	Diagnosis Description	ICD-Codes	Diagnosis Description
(.)		(.)	
(.)		(.)	
(.)		(.)	
(.)		(.)	

2.2 PSYCHIATRIC/SUBSTANCE USE DIAGNOSIS

ICD-DSM-Codes	Diagnosis Description
(.)	
(.)	
(.)	
(.)	

⊕ 2.3 INTELLECTUAL DISABILITY OR RELATED CONDITION (ID/RC) DIAGNOSIS

ICD-DSM-Codes	Diagnosis Description
(.)	
(.)	
(.)	
(.)	

2.4 IF ANY OF THE FOLLOWING IS CHECKED "YES" THE PASRR LEVEL II EVALUATION IS NOT REQUIRED AT THIS TIME (If the Applicant/Resident continues to need Nursing Facility Services please complete a revised Level I Screen prior to the end of stay and refer for a Level II evaluation if needed.)

YES	NO	Description
<input type="checkbox"/>	<input type="checkbox"/>	Medical Diagnosis Only—No Psychiatric or ID-RC Diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	Prior to admission the attending hospital Physician certifies in writing Applicant/Resident will be admitted for "30 days or less" following a medical hospitalization
<input type="checkbox"/>	<input type="checkbox"/>	Hospice Respite stay of "5 days or less" OR Respite stay of "14 days or less"
<input type="checkbox"/>	<input type="checkbox"/>	Provisional stay of "7 days or less". Must call and notify APS and document on the Level I of Emergent Only placement.

Comments and Notes _____

2.5 SERIOUS MENTAL ILLNESS (SMI) CRITERIA

2.5.A Applicant/Resident has a diagnosis that falls within at least one of the following diagnostic groupings of Serious Mental Illness (SMI) as defined by the State Mental Health Authority.

Check all that apply

<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizoaffective Disorder
<input type="checkbox"/> Delusional Disorder	<input type="checkbox"/> Psychosis NOT otherwise specified
<input type="checkbox"/> Major Depression	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Panic Disorder	<input type="checkbox"/> Obsessive Compulsive Disorder
<input type="checkbox"/> Post-Traumatic Stress Disorder	<input type="checkbox"/> Generalized Anxiety Disorder
<input type="checkbox"/> Somatization Disorder	<input type="checkbox"/> Personality Disorders
<input type="checkbox"/> If none of the above SMI diagnostic categories apply, and the Applicant/Resident has a prescribed antipsychotic, antidepressant, mood stabilizer or anti-anxiety medication for a Serious Mental Illness (SMI) within the last year please list diagnosis:	

2.5.B Please note source(s) of diagnosis information:

<input type="checkbox"/> H&P	<input type="checkbox"/> Family	<input type="checkbox"/> MD	<input type="checkbox"/> Applicant/Resident
<input type="checkbox"/> Suspected	<input type="checkbox"/> Other:		

2.5.C FUNCTIONAL LIMITATIONS *FOR APPLICANT/RESIDENT WITH SMI ONLY:*

IF ANY OF THE BELOW BOXES ARE CHECKED "YES", A LEVEL II PASRR EVALUATION IS NEEDED.

	Care	Key Words/Phrases	YES—Include Collateral	NO
2.5.C1	Interpersonal Symptoms (for individuals with Mental Illness only)	Interpersonal; Serious difficulty interacting with others; Altercations; Evictions; Unstable employment; Frequently isolated; Avoids others	<input type="checkbox"/>	<input type="checkbox"/>
2.5.C2	Completing Tasks (for individuals with Mental Illness only)	Serious difficulty completing tasks; Required assistance with tasks; Errors with tasks; Concentration; Persistence; Pace	<input type="checkbox"/>	<input type="checkbox"/>
2.5.C3	Adapting to Change (for individuals with Mental Illness only)	Self-injurious or self-mutilations; Suicidal; Physical violence or threats; Appetite disturbance; Hallucinations or delusions; Serious loss of interest; Tearfulness; Irritability; Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>

2.6 DEMENTIA DIAGNOSIS *FOR APPLICANT/RESIDENT WITH SMI ONLY:*

IF ANY OF THE BELOW BOXES ARE CHECKED "YES," PLEASE CONTACT YOUR LOCAL PASRR OFFICE TO DETERMINE IF LEVEL II IS NEEDED.

Dementia Diagnosis	Diagnosis Description	YES—Include Collateral	NO
Documented evidence of Dementia diagnosis (Dementia is so severe that the individual will not benefit from SMI services)	Is there a diagnosis of Dementia?	<input type="checkbox"/>	<input type="checkbox"/>
	Has a medical Dementia work-up been completed?	<input type="checkbox"/>	<input type="checkbox"/>
	Has a comprehensive mental status evaluation been completed?	<input type="checkbox"/>	<input type="checkbox"/>

SMI Comments and Notes _____

- Level I Screen indicates referral for Level II evaluation SMI is NOT needed
- Level I Screen indicates referral for Level II evaluation SMI is needed (If the Applicant/Resident has SMI and ID-RC, refer to BOTH local mental health PASRR office and the State Intellectual Disability Authority)

Date of Referral to Local PASRR Office: ____/____/____ Name of Person Contacted: _____
 Name of Agency Contacted: _____ Name of Evaluator: _____
 Reason for Screen Out: _____

SECTION 3

3.1 INTELLECTUAL DISABILITY OR RELATED CONDITION (ID-RC) CRITERIA

The Applicant/Resident has a diagnosis that falls within at least one of the following diagnostic groupings:

(Check all that apply)

<input type="checkbox"/>	Documented Evidence of Intellectual Disability (onset before age 18 years old)
<input type="checkbox"/>	Cerebral Palsy (onset before age 22 years old)
<input type="checkbox"/>	Acquired/Traumatic Brain Injury (onset before age 22 years old)
<input type="checkbox"/>	Epilepsy/Seizure Disorder (onset before age 22 years old)
<input type="checkbox"/>	Autism (Autism Spectrum Disorder) (onset before age 22 years old)
<input type="checkbox"/>	Other Related Conditions (e.g. Spina Bifida, Prader-Willi, Fragile-X, Fetal Alcohol Syndrome, Down Syndrome) (onset before age 22 years old) List Diagnosis/Condition:

OR

3.2 without an Intellectual Disability or Related Condition (ID-RC) diagnosis, there are indications the person may have an Intellectual Disability or Related Condition. (Check all that apply)

<input type="checkbox"/>	Receipt of Services by ID-RC Agency (public or private) past, present and/or referrals
<input type="checkbox"/>	The presence of cognitive or behavioral indicators of cognitive/intellectual deficits prior to age 22 years old
<input type="checkbox"/>	A history of significant developmental delays
<input type="checkbox"/>	Special Education classification, such as Intercultural Disability, Autism, Multiple Disability, Other Health Impaired or Traumatic Brain Injury that indicates Intellectual Disability or a Related Condition

AND

3.3 FUNCTIONAL LIMITATIONS (contact local PASRR office for ruling)

For the Applicant/Resident to have Related Conditions the Applicant/Resident must have an identified condition and meet all the following requirements for that specific condition:

<input type="checkbox"/>	Occurred prior to his/her 22 nd Birthday
<input type="checkbox"/>	Is likely to continue throughout his/her life
<input type="checkbox"/>	Has resulted in significant functional deficits in at least 3 of the following areas (Circle all that apply): Self-care Learning Mobility Self-direction Capacity of independent living Understanding and use of language

Level I Screen indicates referral for Level II evaluation for ID-RC is NOT needed.

Level I Screen indicates referral for Level II evaluation for ID-RC is needed.

If the Applicant/Resident has BOTH SMI and ID-RC, refer to BOTH your local mental health PASRR office and the State Intellectual Disability Authority

Date of Referral to ID-RC PASRR Office ____/____/____ Name of Person Contacted: _____
Name of Agency Contacted: _____ Name of Evaluator: _____
Reason for Screen Out: _____

ADDITIONAL SMI and/or ID-RC COMMENTS:

Updating Level II/Collateral Client Search Screen

1. On the Client Search screen type in the Level I number and click search.
2. Click on the Level I number on the right of your screen

PASRR UTAH DEPARTMENT of HUMAN SERVICES 

Home Client Search Forms Reports Maintenance Invoice and Payment Screen Help Logout Version 5.1.89

Client Search Screen

Level I Number

Last Name

First Name

Last 4 SSN

Birth Date MM/DD/YYYY

Client Name	Birth Date	Last 4 SSN	Evaluation Date	Evaluation Type	Status	PASRR
Mickey M.	10/24/1949	0123	11/07/2013	Pending		866565

* To add a new PASRR Evaluation for an existing client, search and select client by last name
** To modify an existing PASRR Evaluation select the correct PASRR Level I Number

Updating Level II/Collateral

3. Click on the Determination Tab
4. Notice this evaluation's status is "In Evaluation" which will allow you to make changes.
5. Click on the Edit button (check to make sure you are clicking the Edit on the line without a Letter of Determination).

PASRR UTAH DEPARTMENT of HUMAN SERVICES 

Home Client Search Client Evaluation **Determination** Forms Reports Maintenance Invoice and Payment Screen Help Logout Version 5.1.89

State Determinations Selection

Mickey Mouse
Level #: 866565
Status: **In Evaluation**
Pending
Assessment Date: 10/19/2019
Admission Date:

Determination Type	Evaluation Received Date	Letter of Determination	Level II/Collateral	Rural Flag	Edit Collateral	NSC
Pre Admission	11/07/2013	Convalescent	Please contact the Nursing facility for the Level II collateral		<input type="button" value="Edit"/>	
Initial	11/07/2013	Reassessment End of Convalescent Stay	Please contact the Nursing facility for the Level II collateral		<input type="button" value="Edit"/>	
Assessment Update	10/31/2019		Testing Collateral.pdf		<input type="button" value="Edit"/>	

Updating Level II/Collateral

9. You will get a green notice at the top indicating the Collateral successfully added and Collateral successfully deleted.

In the below illustration note the name of the file is now changed from Testing Collateral to Testing II.

PASRR UTAH DEPARTMENT of HUMAN SERVICES

Home Client Search Client Evaluation Document Generation Forms Reports Maintenance Invoice and Payment Screen Help Logout Version 5.1.89

Collateral successfully added, processing complete for this Client.
Selected Collateral was successfully deleted.

Client Level II / Collateral

Check here to indicate Rural Evaluation

Documented Collateral

[Testing II.pdf](#)

Please select the Client's Level II / collateral file Browse...

ICD-10 Codes

F25 Schizoaffective disorders

Select One

Mickey Mouse
Level I: 866565
Status: In Evaluation
Pending
Assessment Date: 10/19/2019
Admission Date: