

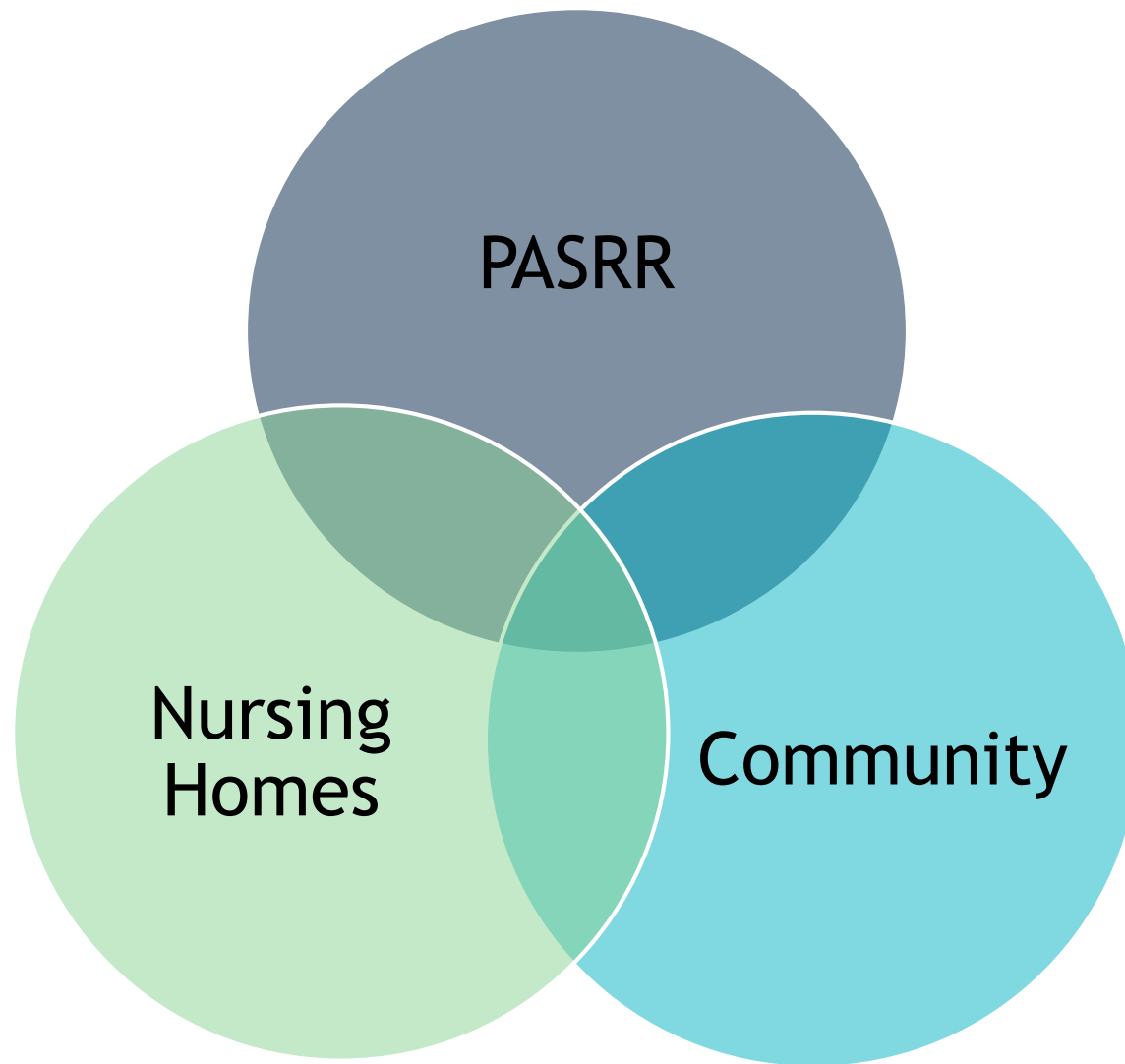


# PASRR Training to MCO

November 17, 2015

# The Importance of PASRR

- ▶ PASRR is a federal requirement created in 1987 through language in the Omnibus Budget Reconciliation Act (OBRA). It has three goals
  - To ensure that individuals are evaluated for evidence of possible mental illness (MI) and/or intellectual disabilities and related conditions (ID/RC).
  - To see that they are placed appropriately, in the least restrictive setting possible.
  - To recommend that they receive the services they need, wherever they are placed.
- ▶ PASRR is an important tool for states to use in rebalancing services and complying with Olmstead v. L.C. (1999)



# Key Milestones in PASRR & Related Efforts

▶ Legal/Regulatory Milestone	Act	Year
▶ Establishment of Title XIX (Medicaid)	SSA	1965
▶ Creation of 1915(c) waivers	SSA	1981
▶ Establishment of PASARR	OBRA	1987
▶ Required start of PASARR	OBRA	1989
▶ Americans with Disabilities Act (ADA)	ADA	1990
▶ Publication of PASARR Final Rule	--	1992
▶ Incorporation at 42 CFR 483.100-138	--	1994
▶ Elimination of Annual Resident Review (now PASRR)	BBA	1997
▶ <i>Olmstead v. L.C.</i>	--	1999
▶ Establishment of 1915(j), 1915(i), MFP	DRA	2005
▶ Changes to 1915(i), creation of 1915(k), more MFP	ACA	2010
▶ Roll-out of MDS 3.0 with Q.A1500 and new Section Q	--	2010

# A Few Preliminaries

- ▶ PASRR is part of Medicaid & Federal Requirements for states.
- ▶ PASRR agencies are making determinations and authorizations for Medicaid nursing facility payment and services.



# Who does PASRR apply to?

All persons seeking admission to Medicaid certified NF including:

- Individuals who are private pay
- Individuals whose stay will be paid by insurance
- Individuals whose stay will be paid by Medicare
- Individuals whose stay will be paid by Medicaid

# Federal Regulations

- 42 CFR 483 Sec 100-138 outlines states' responsibilities.  
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html>
- State Operations Manual, Long Term Care Facilities:  
[http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf)

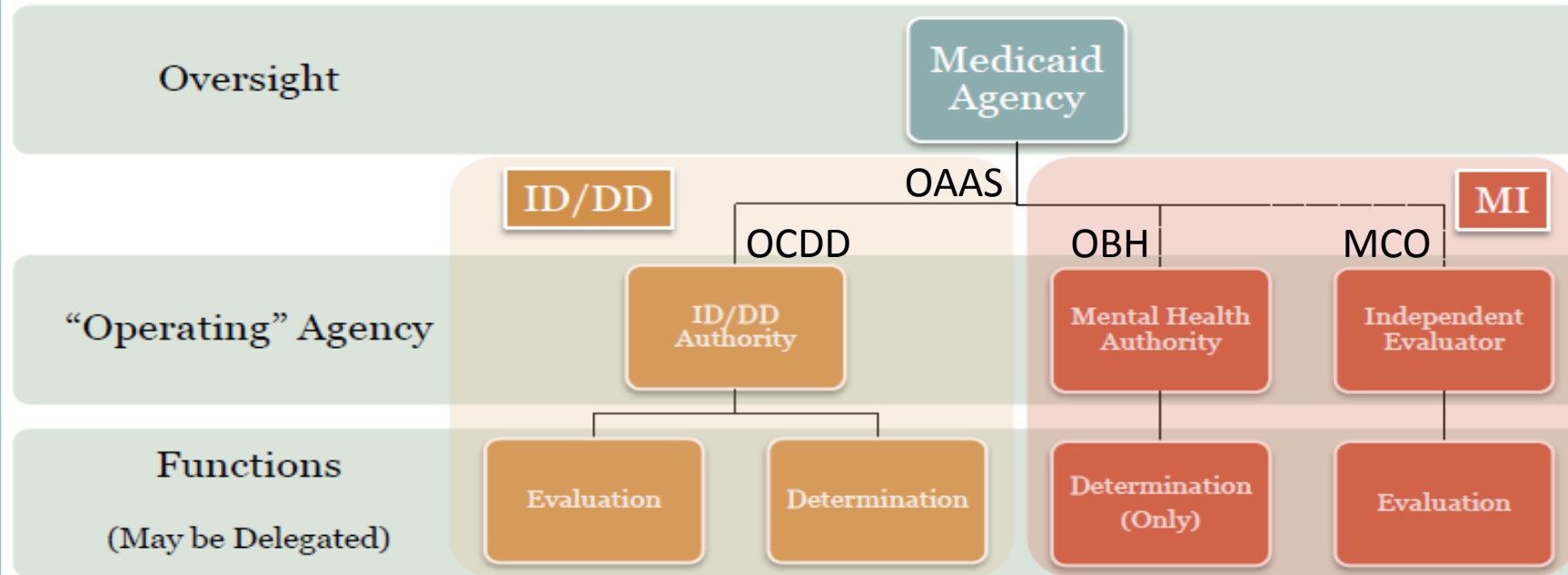
# Roles of agencies



# Roles of Agencies

- ▶ Medicaid has ultimate authority over PASRR
  - LA-Medicaid has dedicated Level I review to OAAS.
  - Level II is the responsibility of the State Mental Health Authority (SMHA) or State Mental Retardation Authority (ID/DD).
    - However, Medicaid can't countermand determinations made by Level II authorities.

# Roles & Responsibilities



# Level I (broad screening by OAAS)

- Applies to every admission to every Medicaid certified NF
- Screen person for any/all signs of MI, ID or related condition (RC)
- Typically done by hospital/health care entity who is referring the person (e.g., NF, referring hospital or MD, or contracted health services agencies)
- Must be signed by Louisiana licensed MD
- Applicants who show signs of MI, ID/RC in Level I, and who do not have previous evaluations that can render determination, must undergo Level II PAS
- Dated 30 days prior to date of admission.

## Level II (in-depth evaluation/determination by OBH & OCDD)

- ▶ Individuals identified by the Level I authority as possibly having MI/ID/DD are referred for a Level II evaluation.
- ▶ Level II evaluation are conducted by an independent entity of the state's Mental Health Authority (MHA) if MI and by the state's Mental Retardation Authority (ID/DDA) if ID/DD/RC.
- ▶ Level II determinations are conducted by the state's MHA and ID/DDA .
- ▶ If, at any time during the level II, the SMHA/SID/DDA finds the individual being evaluated does not have MI/ID/DD/RC, the evaluation ends.
- ▶ Individuals with MI & ID/DD will have concurrent evaluations with OCDD making final placement decision.

# Level II Preadmission Screening

- ▶ **Determines the need for NF** services based on physical and mental condition.
- ▶ **Determines the need for specialized services.**
- ▶ **Determination Timeliness:** Must be made within writing within an annual average of 7-9 working days of referral to MI or ID/DD. **MCOs have 4 calendar days to complete Level II evaluations.**

**Preadmission Screening must be completed PRIOR to Nursing Home admission**

# Types of Level II Requests

- ▶ **Preadmission Screening (PAS)**-prior to Nursing facility placement
- ▶ **Resident Reviews (RR)**-for individuals already in nursing facilities who have a change in condition.
- ▶ **Extension Requests**- treated like a RR when a nursing facility is requesting to extend a temporary nursing facility authorization.

# Resident Review

- ▶ Triggered when there is a “significant change” in resident’s status.
  - occurs when there is a physical or mental change in the condition of a resident who has mental illness or mental retardation/related disorder. This condition would not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions. This change would have an impact on more than one area of the resident’s health status and would require interdisciplinary review or revision of the plan of care, or both.
- ▶ The nursing facility is responsible for reporting any significant change in the resident’s condition to the level II authority (OBH and/or OCDD).

# MDS 3.0 “Significant Change” and PASRR Level II Referral

- ▶ PASRR Level II functions as an independent assessment process for this population with special needs, in parallel with the facilities assessment process.
  - PASRR is an OBRA provision that is required to be coordinated with the recent assessment process.
  - If a SCSA (Significant Change in Status Assessment) occurs.
  - The NF must provide the SMHA/SID/DDA with referrals independent of findings of the SCSA.
- ▶ NF should have a low threshold for referral so the Level II authorities can exercise their expert judgment above when a Level II evaluation is needed.
- ▶ NF should refer to Level II as soon as the criteria indicating a significant change is evident and not wait until SCSA is complete.

# Referral for Level II Resident Review

## Evaluations: Previously Identified by PASRR

- ▶ 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.

# Referral for Level II Resident Review: Previously Identified by PASRR Cont'd

- ▶ A resident who indicates a preference (may be communicated verbally or through other forms of communication, including behavior) to leave the facility.
- ▶ A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation and determination. (Note that a referral for a possible new Level II PASRR evaluation is required whenever such a disparity is discovered, whether or not associated with a SCSA.)

## Referral for Level II Resident Review Evaluations: Not Previously Identified by PASRR

- ▶ A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis).
- ▶ A resident whose mental retardation as defined under 42 CFR 483.100, or condition related to mental retardation as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR.
- ▶ A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.

# Specialized Services

- ▶ **Any service or support recommended by an individual Level II determination that a particular nursing facility resident requires due to mental illness, intellectual disability or related condition, that supplements the scope of services that the facility must provide under reimbursement as nursing facility services.**
  - Must be provided to residents of NFs or individuals residing in the community (not individuals in acute care psychiatric hospitals or ICF/IIDs).
  - Not limited to what a particular payer will cover (i.e. not just Medicaid services); and
  - Can't be a finite set, but must include whatever disability specific services an individual needs.
- ▶ **The State must provide or arrange for the provision of the Specialized Services needed by the individual while he or she resides in the NF. [§ 483.116(b)]**
  - The state sets up the mechanism to pay for these services and see that needs are met. (Part of NF services, NF SRS, or defined as Specialized Services)

# PASRR Components

## ► Comprehensive evaluation & determination

- Confirms/disconfirms suspected disability noted in Level I PAS – e.g., presence/absence of Serious Mental Illness (SMI) and/or presence of ID/DD/RC
- Makes placement recommendations (i.e., appropriateness of NF placement?)
- Makes treatment recommendations

# PASRR Components (cont.)

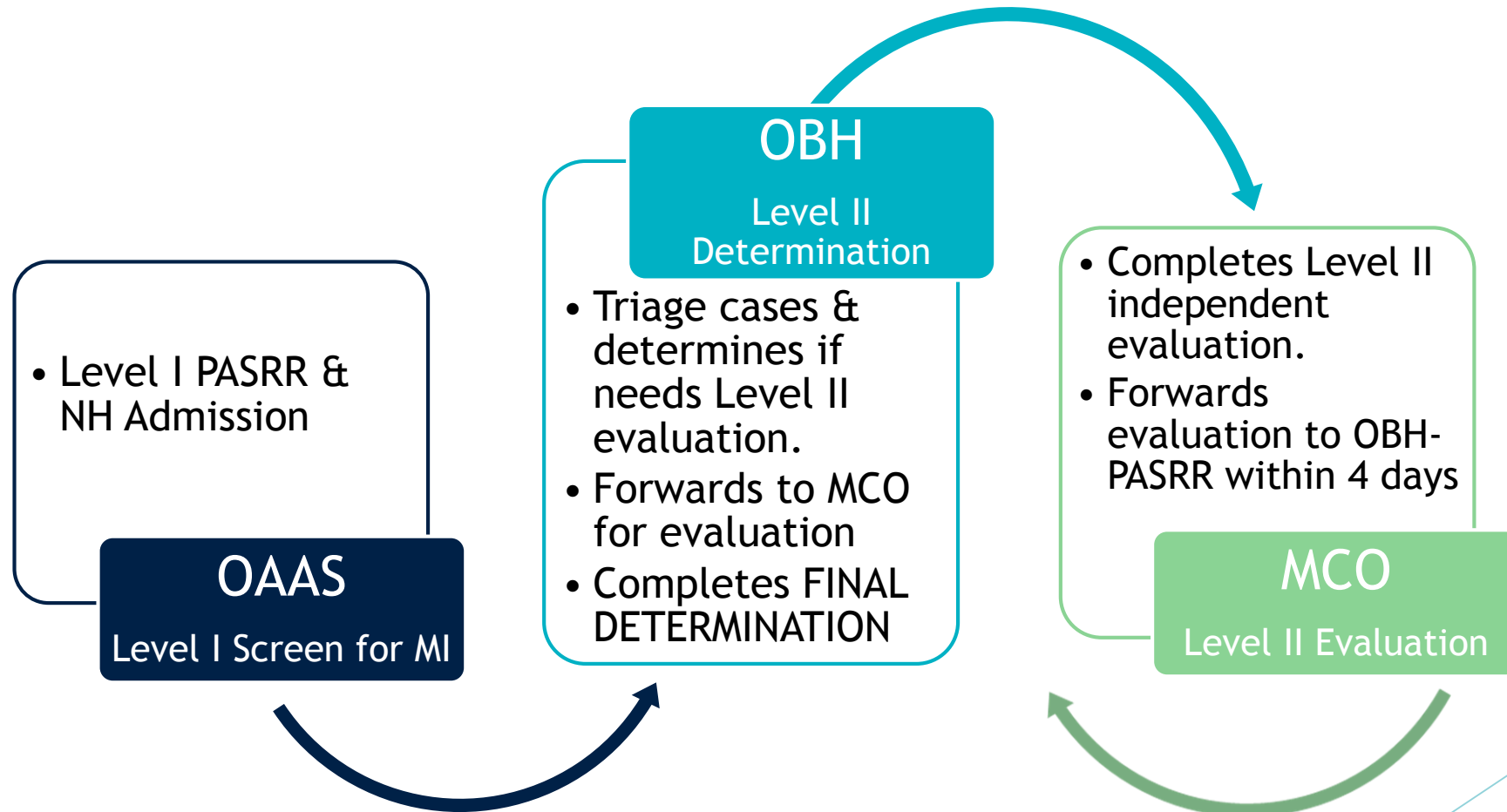
## ► **Report/notification**

- Explains PASRR outcome
- Appeal rights

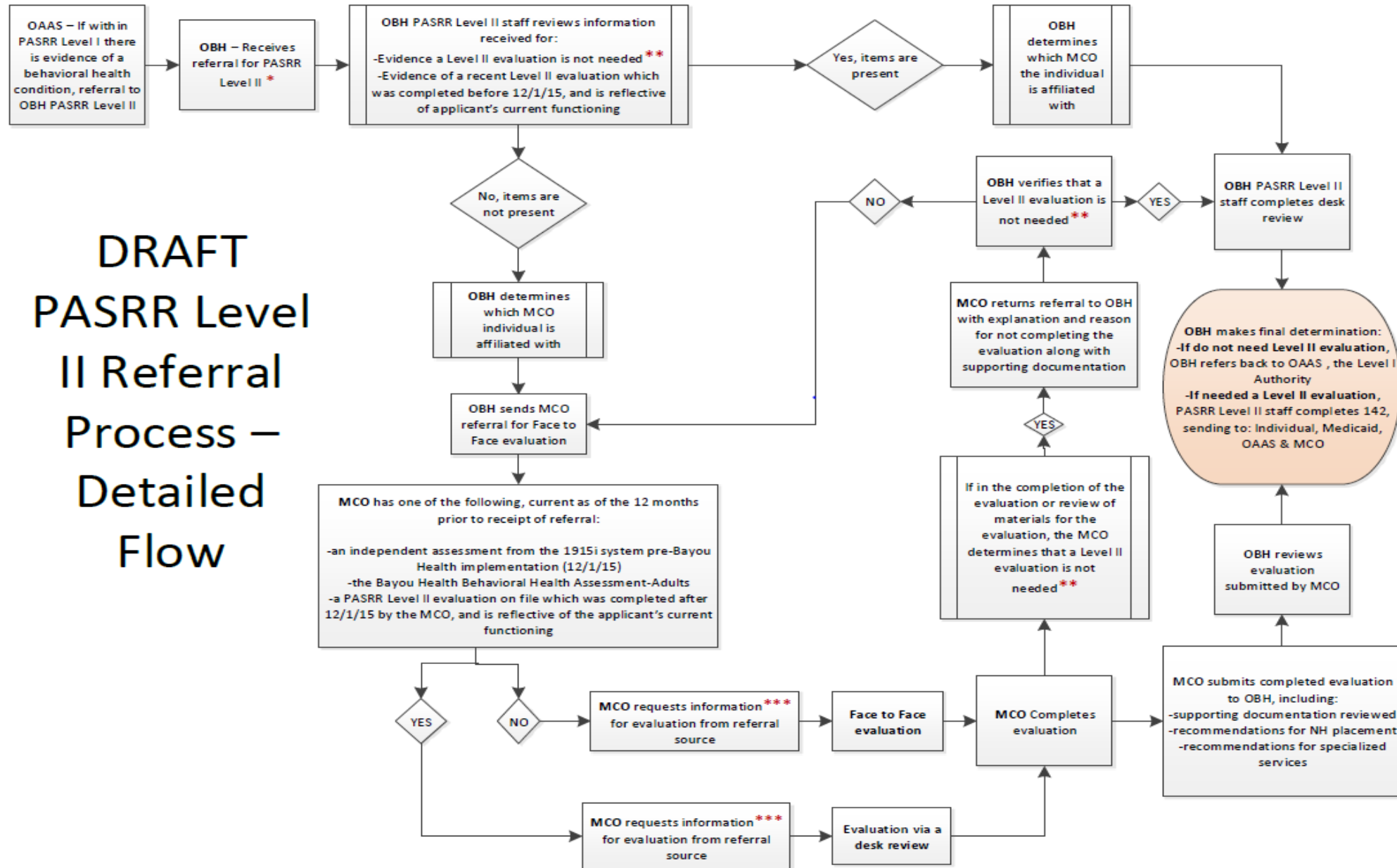
## ► **Follow-up assessments**

- (includes RR & ongoing monitoring for placement and treatment appropriateness)

# MCO role in Evaluations & Determinations



# DRAFT PASRR Level II Referral Process – Detailed Flow



# Information you will receive from OBH

- ▶ Note requesting Level II evaluation and the reason the evaluation is needed.
- ▶ New admission to a NF
  - Level Of Care Eligibility Tool and Results
  - Level I PASRR
  - Any Records Received
- ▶ After NF admission
  - Any records received
  - These may include Minimum Data Set, records from a hospital admission, etc.

# Diagnoses: Serious Mental Illness

## According to 42 CFR 483.102

- ▶ **Diagnosis:** Make or confirm a diagnosis of major mental illness diagnosed by DSM, 3<sup>rd</sup> Edition, revised 1987.
  - DSM5: Schizophrenia Spectrum & Other Psychotic Disorders, Bipolar Related Disorders, Depressive Disorders, Anxiety Disorders, Personality Disorders, Trauma Related Disorders, or other disorder that leads to chronic disability.
  - Not primary diagnosis of dementia.
  - Not episodic/situational
- ▶ **Disability:** Functional limitations in major life activities within the last 3- 6 months. One of the following characteristics on a continuing or intermittent basis:
  - Interpersonal functioning
  - Concentration, persistence, and pace
  - Adaption to change
- ▶ **Duration:** Recent major treatment episodes or significant disruption within the past 2 years. (hospitalizations, need for intensive community services)

# Types of PASRR Determinations

- ▶ Individualized determinations
- ▶ Exemptions/Exclusions
- ▶ Advanced Group/Categorical Determinations
  - Developed by the states and included in the state plan.
  - Applies to people with Level II conditions as a way to expedite decisions regarding a person's needs when a full Level II assessment may not be necessary.

# Individualized Determinations

- ▶ Based on more extensive assessment information and will be required unless the person meets the criteria for a categorical determination.
- ▶ A Full Level II evaluation by the MCO and Determination is done.
- ▶ Permanent Approvals or Time-limited Approvals.
  - MCOs will be making recommendations as to the length of time someone may need in a NF.

# Approvals (Time-Limited/Short-Term)

- ▶ OBH & OCDD may approve an individual for a specified time frame rather than a permanent status.
- ▶ This is typically done when the Level II authority determines after review that an individual's condition is expected to improve to the point where transition to the community is likely.

# Hospital Exemptions

- ▶ The only true exemption from PASRR.
- ▶ For post-acute stays for acute illness lasting less than 30 days.
- ▶ If longer, a PASRR must be completed by day 40.
- ▶ It is the nursing facility's responsibility to notify the Level II authority by day 30 if they are requesting an extension of the hospital exemption.
  - Once the NF notifies OBH, OBH will make a referral to the MCO if a Level II evaluation is needed.
  - The MCO will also monitor to ensure that individuals in NF that entered under a HE received a Level II Determination.
- ▶ Any request after day 40 and the expiration of the 142 will be treated as a new admission and must re-start the process.

**NOT USED TO BYPASS LEVEL II  
PROCESS**

# Louisiana Advanced Group/Categorical Determinations

CATEGORICAL DETERMINATION	Specialized Services
Convalescent care from an acute physical illness (not exemption)	Are SS needed?
Terminal illness (42 CFR 418.3)	Are SS needed?
Severe Physical Illness	Are SS needed?
Delirium (30 days)	Not needed
Emergency Situations/Protective services (7 days)	Not needed
Respite (30 days)	Not needed
Dementia & MR	Not needed. Is NF needed?

# PASRR Exclusion & Primary Dementia

- ▶ Invoked only when dementia co-occurs with serious mental illness and:
  - Dementia is primary and advanced such that the mental illness will not likely be the primary focus of treatment attention again for the individual.
  - The burden is on the referral source to clearly support and document that the dementia is both advanced and will remain primary over the mental health diagnosis.
  - If any doubt, a Level II evaluation must be conducted

# Categorical Definitions

- ▶ Convalescent care from an acute physical illness which--
  - Required hospitalization; and
  - Does not meet all the criteria for an exempt hospital discharge, which is not subject to preadmission screening, as specified in § 483.106(b)(2).
- ▶ Terminal illness: must be a documented terminal illness. If condition improves to the point where the individual may benefit from specialized services then a request for Level II review must be submitted;
- ▶ Severe physical illnesses such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services;

# Categorical Definitions Cont'd...

- ▶ Provisional admissions pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears;
- ▶ Provisional admissions pending further assessment in emergency situations requiring protective services, with placement in a nursing facility not to exceed 7 days; and
- ▶ Very brief and finite stays of up to a fixed number of days to provide respite to in-home caregivers to whom the individual with MI or ID/DD/RC is expected to return following the brief NF stay.

# OBH staff complete Level II determination without sending to MCO when:

- ▶ Evidence the member does not have a serious mental illness (SMI)
- ▶ Evidence of Advanced Group/Categorical Determination (Convalescent care from an acute physical illness, terminal illness, severe physical illness, delirium, emergency situation, respite, primary dementia)
- ▶ OBH has record of recent Level II evaluation which was completed before 12/1/15, and is reflective of the applicant's current functioning\*

\*if applicant's status has changed since last evaluation (i.e. hospitalization, change in residence, change in symptom, or severity of symptom, etc.), then a face to face evaluation will be needed

# OBH referral to the MCO

- ▶ OBH will email the MCO at a designated email address requesting a Level II evaluation.
- ▶ OBH may also contact an identified MCO individual to follow-up with Level II evaluations, to verify information, or ask additional questions if necessary.

# MCO may complete a desk review for a Level II evaluation in the following circumstance:

- ▶ If the member has an independent behavioral health evaluation on file that has been conducted within the last 12 months prior to receipt of referral and reflects the member's **current functioning\***
  - Evaluations that may be used include the following:
    - ◆ An independent assessment from the 1915i system pre-Bayou Health implementation(12/1/15)
    - ◆ The Bayou Health Behavioral Health Assessment-Adults
    - ◆ PASRR Level II evaluation
      - Completed after 12/1/15 by the MCO
- ▶ OBH has the final decision in all cases if a face to face is required or if a record review is sufficient.

**\*if applicant's status has changed since last evaluation (i.e. hospitalization, change in residence, change in symptom, or severity of symptom, etc.), then a face to face evaluation will be needed**

# MCO does not complete Level II evaluation and returns referral to OBH in following circumstances:

*(The MCO would stop the evaluation, return the referral back to OBH with an explanation and reason for not completing the evaluation along with supporting documentation)*

- ▶ The MCO receives evidence that individual does not have a serious mental illness.
- ▶ The MCO finds evidence of an advanced group/categorical decision whereby the member meets criteria for NF placement but is **not expected to benefit from specialized behavioral health services due to the severity of their condition.**
- ▶ Upon review, OBH may re-submit a referral to the MCO for a Level II face-to-face evaluation.

# Written Evaluation Report Components

## (CFR 483.128)

- ▶ Name and professional title of person(s) who performed evaluation(s) and date each portion of evaluation was administered
- ▶ Summary of findings-summary of medical and social history, including positive traits or developmental strengths and weaknesses or developmental needs of the person.
- ▶ Explains the categorical determination(s) made and if only one of the required determinations can be made categorically, describes the nature of any further screening which is required
- ▶ If NF services are recommended included specific service needs of person
- ▶ Whether any specialized services or services of a lesser intensity are needed and the specific services recommended
- ▶ The bases for the reports conclusions, including discussion of possible alternative placements.
- ▶ Termination of the evaluation

# Completing the “PASRR Level II Independent Behavioral Health Comprehensive Evaluation” Form



### DEMOGRAPHIC INFORMATION

Assessment Date				Medicaid Number:		
Recipient Name: (first, middle, last)						Bayou Health Plan:
Age:	DOB:	Ethnicity:	Gender:	Gender Expression:	Marital Status:	SSN:
LOCUS: (date and score)*attach copy of LOCUS				PRIMARY DIAGNOSIS:		
Facility/Agency/Individual Requesting Placement (please include contact person, phone#, and fax to send determination):						
Current Location of the Individual:						
Type of Referral: <input type="checkbox"/> Pre-admission; <input type="checkbox"/> Resident Review; <input type="checkbox"/> Extension Request						

- Facility/Agency: This is usually on the fax cover sheet on the Level I PASRR or records from the provider.
- Current Location of the individual: OBH will provide this information on the referral note if known. The referring provider should also have this information available.
- Type of Referral: OBH will provide this information on the referral note.

## TYPE OF EVALUATION

<input type="checkbox"/> <b>FACE TO FACE EVALUATION</b>		
<input type="checkbox"/> <b>DESK REVIEW</b>	<p><b>REASON FOR DESK REVIEW (one of the following 12 months prior to receipt of the referral)</b></p> <p><input type="checkbox"/> an independent assessment from the 1915i system pre-Bayou Health implementation (12/1/15): date of assessment _____ *Please attach</p> <p><input type="checkbox"/> a Bayou Health Behavioral Health Assessment – Adults post Bayou Health implementation (12/1/15): date of assessment _____ *Please attach</p> <p><input type="checkbox"/> a PASRR Level II evaluation is on file: date of assessment _____ *Please attach</p>	<p><b>COMMENTS:</b></p> <p style="color: red;"><i>Current records must still be requested and the Level II form completed for desk reviews.</i></p> <p style="color: red;"><i>Current mental status is not completed for desk reviews.</i></p>
<input type="checkbox"/> <b>NO EVALUATION COMPLETED, SENT BACK TO OBH</b>	<p><b>REASON FOR SENDING BACK TO OBH</b></p> <p><input type="checkbox"/> the individual <u>does not have a serious mental illness</u></p> <p><input type="checkbox"/> <u>Categorical Decision</u></p> <p><b><u>Type of Categorical Decision (check if applicable):</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Terminal illness</li> <li><input type="checkbox"/> Severe Physical illness</li> <li><input type="checkbox"/> Delirium</li> <li><input type="checkbox"/> Primary Dementia</li> <li><input type="checkbox"/> Convalescent Care</li> <li><input type="checkbox"/> Emergency/Protective Services</li> <li><input type="checkbox"/> Respite Services</li> </ul>	<p><b>COMMENTS:</b></p> <p style="color: red;"><i>Include rationale for sending back and note the records or evidence to support the decision</i></p>

# MCO Documentation of Categoricals

- ▶ A Level II evaluation is not needed for individuals without SMI and Categorical Determinations. MCOs will send these back to OBH for a final determination along with appropriate documentation on the “PASRR Level II Independent Behavioral Health Comprehensive Evaluation”

<input type="checkbox"/> NO EVALUATION COMPLETED, SENT BACK TO OBH	<b>REASON FOR SENDING BACK TO OBH</b> <input type="checkbox"/> the individual <u>does not have a serious mental illness</u>  <input type="checkbox"/> <u>Categorical Decision</u> <b><u>Type of Categorical Decision (check if applicable):</u></b> <ul style="list-style-type: none"><li><input type="checkbox"/> Terminal illness</li><li><input type="checkbox"/> Severe Physical illness</li><li><input type="checkbox"/> Delirium</li><li><input type="checkbox"/> Primary Dementia</li><li><input type="checkbox"/> Convalescent Care</li><li><input type="checkbox"/> Emergency/Protective Services</li><li><input type="checkbox"/> Respite Services</li></ul>	<b>COMMENTS:</b>
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# Required Information for Level II Review-MI

## ► Comprehensive history and physical

- complete medical history, review of all body systems, specific evaluation of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, abnormal reflexes, and in the case of abnormal finding that are the basis for NF placement, additional evaluations conducted by appropriate specialists.

## ► Comprehensive drug history including current and immediate-past use of medications that could mask or mimic mental illness, side-effects and adverse drug reactions.

## ► Psychosocial evaluation, including current living arrangements and medical and social supports.

## ► Comprehensive psychiatric evaluation

- Evaluation of intellectual functioning, memory functioning, and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence of content of delusions) and hallucinations.

## ► Functional Assessment

## ► Primary Dementia: Corroborative testing or other information available to verify the presence of progression of dementia (Dementia work up, comprehensive mental status exam, CT scan, etc.).

## ► Records that speak to the reason for NF placement, including documentation of categoricals.

It is the MCOs responsibility to obtain documentation

### DOCUMENTS REVIEWED/INDIVIDUAL INTERVIEWS

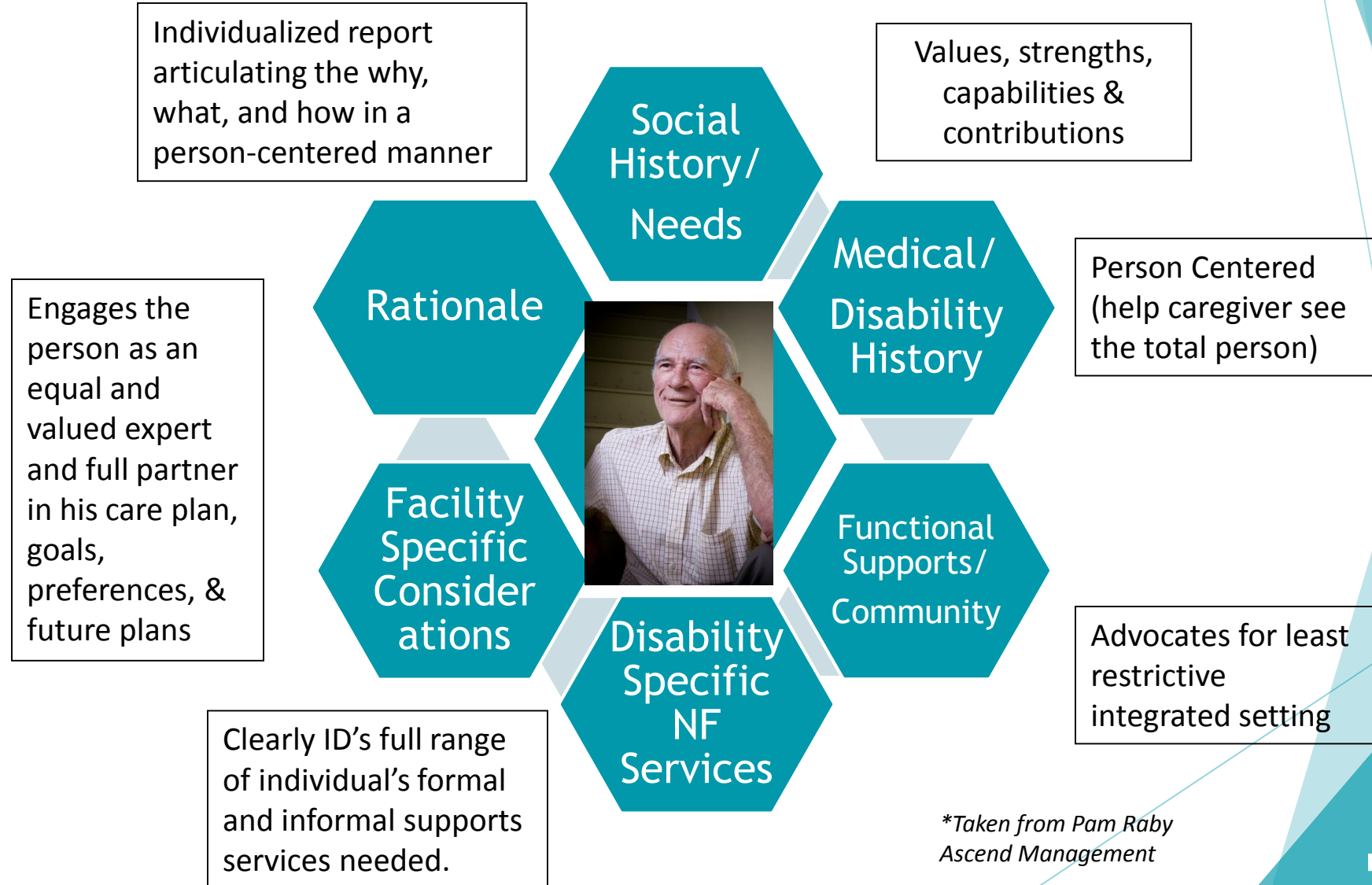
The following items were available/reviewed as part of this screening (attach all records reviewed):

- ☐ Medical H&P   ☐ Functional Assessment   ☐ Psychiatric Evaluation   ☐ Psychosocial Evaluation   ☐ Comprehensive Medications
- ☐ Psychological Testing Results   ☐ Progress Notes   ☐ Additional Labs or Consults: \_\_\_\_\_
- ☐ Other \_\_\_\_\_

The following individuals were interviewed:

- ☐ Individual   ☐ Family/significant other \_\_\_\_\_ (specify)   ☐ Legal representative/Guardian/Conservator \_\_\_\_\_ (specify)
- ☐ Other agency for interdisciplinary coordination (specify) \_\_\_\_\_
- ☐ Other \_\_\_\_\_

# Summary of Findings



*\*Taken from Pam Raby  
Ascend Management*

# Social History

*Values, strengths, capabilities, contributions*



## ► Makes us who we are

- Reclaims identity
- Powerful tool for building relationships with the provider and gaining insights into what may or may not work in terms of support or care arrangements.
- Creates connection-helps caregivers and others gain awareness of the individual as a person.

## SOCIAL HISTORY

X. LEGAL STATUS			
<b>Current Legal Status:</b> <input type="checkbox"/> None; <input type="checkbox"/> Parole; <input type="checkbox"/> Probation; <input type="checkbox"/> Charges Pending; <input type="checkbox"/> Court-Ordered Outpatient Treatment; <input type="checkbox"/> AOT; <input type="checkbox"/> Judicial; <input type="checkbox"/> Other; Comment/Detail:	<b>Past Legal Status:</b> <input type="checkbox"/> None; <input type="checkbox"/> DWI; <input type="checkbox"/> Prior Arrests; <input type="checkbox"/> Prior Incarcerations; <input type="checkbox"/> Other;  Comment/Detail:		
XI. FAMILY HISTORY (relationship status with relatives, family involvement in treatment, and living status of significant relatives):			
<b>Custodial Status:</b> <input type="checkbox"/> Independent Adult; <input type="checkbox"/> Family Member; <input type="checkbox"/> Gov't/Judicial; <input type="checkbox"/> Other: (specify)	<b>Contact Info:</b> Name:	Relation	Phone #
<b>Adverse Circumstances in Family of Origin:</b> <input type="checkbox"/> N/A; <input type="checkbox"/> Poverty; <input type="checkbox"/> Criminal Behavioral; <input type="checkbox"/> Mental Illness; <input type="checkbox"/> Substance Use; <input type="checkbox"/> Abuse; <input type="checkbox"/> Neglect; <input type="checkbox"/> Domestic Violence; <input type="checkbox"/> Violence; <input type="checkbox"/> Trauma; <input type="checkbox"/> Other/Describe:			
<b>Family Stress:</b> <input type="checkbox"/> Low Stress; <input type="checkbox"/> Mildly Stressful; <input type="checkbox"/> Moderately Stressful; <input type="checkbox"/> Highly Stressful; <input type="checkbox"/> Extremely Stressful <input type="checkbox"/> Other/Describe:			
<b>Family Supports:</b> <input type="checkbox"/> Highly Supportive; <input type="checkbox"/> Supportive; <input type="checkbox"/> Limited Support; <input type="checkbox"/> Minimal Support; <input type="checkbox"/> No Support <input type="checkbox"/> Other/Describe:			
<b>Additional Comments:</b>			
XII. TRAUMA HISTORY			
<b>History of Trauma:</b> <input type="checkbox"/> None; <input type="checkbox"/> Experienced; <input type="checkbox"/> Witnessed; <input type="checkbox"/> Abuse; <input type="checkbox"/> Neglect; <input type="checkbox"/> Violence; <input type="checkbox"/> Sexual Assault; <input type="checkbox"/> Other/Describe:			

<b>XIII. LIVING SITUATION</b> (Current status and functioning)	
<p><b>a. Primary Residence:</b> <input type="checkbox"/> Own Home; <input type="checkbox"/> Apartment; <input type="checkbox"/> Relative's Home; <input type="checkbox"/> Group Home; <input type="checkbox"/> Homeless; <input type="checkbox"/> Nursing Facility; <input type="checkbox"/> Other/Describe:</p> <p><b>How long at current residence?</b></p> <p><b>Family/Household Composition:</b></p> <p><b>Source of meals/food:</b> <span style="float: right;"><b>Means of transportation:</b></span></p> <p><b>Additional Comments:</b> (Include psychological and social adjustments made to disabilities and/or disorders.)</p>	
<p><b>b. Needs</b> -List what is needed to improve/maintain daily living situation (Ex. Transportation, ability to cook independently, housing subsidy, money in savings, care-giver resource assessment, etc.)</p>	
<p><b>c. Preferences</b> - Include things recipient feels will enhance his/her living situation.</p>	
<p><b>d. Strengths</b> -List assets, service options, and resources the person has to meet needs, including available housing options. (Ex. Knows area, applied for housing subsidy, can live with family member, unpaid care-giver resource available, etc.)</p>	
<p><b>e. Abilities/Interests</b> -Include recipient reported skills, aptitudes, capabilities, talents &amp; competencies that might assist in maintaining or improving living situation.</p>	
<b>XIV. LEARNING/WORKING AND FUNCTIONAL STATUS</b>	
<p><b>a. <u>Employment/Education/Rehabilitation Status:</u></b></p> <p><b>Current source of income:</b> <span style="float: right;"><b>Estimated Monthly Income Amount:</b></span></p> <p><b>Highest Grade or Completed/Degree:</b> <span style="float: right;"><b>Military Status:</b></span></p> <p><b>Difficulties with Reading/Writing:</b> <input type="checkbox"/> No; <input type="checkbox"/> Yes; <span style="float: right;"><b>Military Trauma:</b> <input type="checkbox"/> No; <input type="checkbox"/> Yes;</span></p> <p><b>Current Employment Status:</b> <span style="float: right;"><b>Estimated Literacy Level:</b></span></p> <p><b>Assistive Devices utilized/required:</b> <input type="checkbox"/> No; <input type="checkbox"/> Yes; <span style="float: right;"><b>Prior Employment Status:</b></span></p> <p><b>Additional Comments:</b> (Include psychological and social adjustments made to disabilities and/or disorders.)</p>	
<p><b>c. Abilities/Interests</b> - Include recipient reported skills, aptitudes, talents &amp; competencies that may help maintain or improve socialization &amp; community functioning.</p>	

# Social History Cont'd

- ▶ What would you like staff to know about you and your history?
  - How shall we refer to you?
  - Tell me about you? What you like to do? Enjoy?
    - ◆ What makes a good day? Makes you happy?
    - ◆ Your hobbies?
    - ◆ How do friends or family describe you?
    - ◆ Your past employment?
  - What helps you feel supported?
  - Who helps you feel supported?
  - What do you want others to know about you?

# Social History Cont'd

- ▶ Family Caregiver Questions: What is important for him/her, What should others know?
  - What do you believe is important for him/her?
  - What makes a good day?
  - Communication; interpersonal
  - Lifestyle
  - What makes a bad day?
  - What frustrates him/her?
  - What helps him/her most when it's a bad day?

# Disability History-Treatment History

*Helps Caregivers see the total person*

- ▶ Tell me about your ....(depression, schizophrenia, “nerves”, etc.)
- ▶ Have you ever had to go the hospital for...? About how many times and how long?
- ▶ What has led to those times? Can you name any patterns?
- ▶ What is the longest period of time you remember between hospitalizations? What medications have worked best? Least?
- ▶ What treatments have worked best? Least?
- ▶ Do you remember when you stopped taking medications and why?
- ▶ If you need to go to the hospital, where do you prefer to go?

# Disability History-Individual & Caregiver-Symptoms

- ▶ What are your usual symptoms of depression, bipolar, etc.?
- ▶ What does “typical” for you look like?
- ▶ What causes your symptoms (anxiety, sadness, “voices”) to get worse?
- ▶ Are there signs that help others know you are going down that path?
- ▶ What helps?
- ▶ Can hospitalizations be prevented if symptoms are treated early?
- ▶ Have you ever hurt yourself or someone else? Thought about or tried suicide? How? Have you had any of these feelings lately?

# Disability History: Individual & Caregivers-Current Needs

- ▶ What symptoms are you having now?
- ▶ Are symptoms/behaviors 'typical'/baseline now?
- ▶ Currently, what should the provider monitor?
- ▶ Is there any evidence of suicidal/aggressive behavior?
- ▶ What is the most important to providers to ensure occurs with his treatment plan?
- ▶ What is the most important to providers to ensure occurs in terms of support?

<b>II. PRESENTING PROBLEM/HISTORY OF PRESENT ILLNESS</b> (Including recipient's reason for seeking services, precipitating factors, symptoms, behavioral and functioning impacts, onset/course of issues, <i>current behavioral health providers</i> , services sought and recipient expectation.)						
CURRENT BEHAVIORAL HEALTH PROVIDER NAME:					PHONE NUMBER:	
<b>III. PAST PSYCHIATRIC HISTORY</b> (First onset of illness, past diagnostic and treatment history, medications, hospitalizations-date, length, reasons, & facility):						
Prior Outpatient Mental Health Treatment: <input type="checkbox"/> No; <input type="checkbox"/> Yes; Detail:				Psychiatric Hospitalizations: <input type="checkbox"/> No; <input type="checkbox"/> Yes; Detail:		
Additional History/Comments:						
<b>IV. SUBSTANCE ABUSE/DEPENDENCE</b> (Past use of primary, secondary & tertiary current substance, incl. type, freq, method & age of 1st use.)						
Check any/all that apply in past 12 months: <input type="checkbox"/> Alcohol Use; <input type="checkbox"/> Illegal Drug Use; <input type="checkbox"/> Injected Drug Use ; <input type="checkbox"/> Tobacco Product Use; <input type="checkbox"/> Prescription Drugs Abuse; <input type="checkbox"/> Non-Prescription (OTC) abuse; <input type="checkbox"/> Alcohol and/or Drug Overdose; <input type="checkbox"/> Alcohol and/or Drug Withdrawal; <input type="checkbox"/> Problems caused by gambling; <input type="checkbox"/> Trouble stopping any substance <input type="checkbox"/> Other/Describe:						
Substance Abuse Treatment History: <input type="checkbox"/> None; <input type="checkbox"/> Outpatient; <input type="checkbox"/> Intensive Outpatient; <input type="checkbox"/> Residential/Inpatient;; <input type="checkbox"/> Detox; <input type="checkbox"/> Other/Describe:						
SUBSTANCE TYPE <small>Include all use in last 30 days.</small>	AGE OF 1ST USE	YEARS IN LIFETIME	DAYS IN PAST 30	DAYS SINCE LAST USE	AMOUNT	ROUTE OF ADMINISTRATION
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV <u>Injxn</u> ; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV <u>Injxn</u> ; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV <u>Injxn</u> ; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV <u>Injxn</u> ; <input type="checkbox"/> IV
						<input type="checkbox"/> Oral; <input type="checkbox"/> Nasal; <input type="checkbox"/> Smoking; <input type="checkbox"/> Non-IV <u>Injxn</u> ; <input type="checkbox"/> IV

## CURRENT STATUS

### XV. MENTAL STATUS EXAMINATION

(Circle or Check all that apply)

1. GENERAL APPEARANCE: ☐ Healthy ☐ As stated Age ☐ Older Than Stated Age ☐ Young looking ☐ Tattoos ☐ Disheveled ☐ Unkempt

*Mental Status not completed for Desk Reviews. Only for face to face evaluations.*

### XVIII. PRINCIPAL DIAGNOSES (PROVIDE PRINCIPLE BEHAVIORAL, MEDICAL DIAGNOSES, AND DEVELOPMENTAL DISABILITY)

DIAGNOSIS	SEVERITY, IF APPLICABLE

**XVI. RISK ASSESSMENT:** Assess potential risk of harm to self or others, including patterns of risk behavior and/or risk due to personality factors, substance use, criminogenic factors, exposure to elements, exploitation, abuse, neglect, suicidal or homicidal history, self-injury, psychosis, impulsiveness, etc.

- a. **Risk of Harm to Self:** ☐ Prior Suicide Attempt; ☐ Stated Plan/Intent; ☐ Access to means (weapons, pills, etc.); ☐ Recent Loss; ☐ Presence of Behavioral Cues (isolation, giving away possessions, rapid mood swings, etc.); ☐ Family History of Suicide; ☐ Terminal Illness; ☐ Substance Abuse; ☐ Marked lack of support; ☐ Psychosis; ☐ Suicide of friend/acquaintance;

#### PASRR LEVEL II INDEPENDENT BEHAVIORAL HEALTH COMPREHENSIVE EVALUATION

☐ Other/Describe:

- b. **Risk of Harm to Others:** ☐ Prior acts of violence; If yes, when was the most recent violent act? \_\_\_\_\_; ☐ Destruction of property; ☐ Arrests for violence; ☐ Access to means (weapons); ☐ Substance use; ☐ Physically abused as child; ☐ Was physically abusive as a child; ☐ Harms animals; ☐ Fire setting; ☐ Angry mood/agitation; ☐ Prior hospitalizations for danger to others; ☐ Psychosis/command hallucinations; If yes, is there a history of acting on any commands to harm others? ☐ Yes ☐ No; ☐ Other/Describe:

- c. **Risk of Harm to Self or Others Rating:** (From LOCUS Risk of Harm Evaluation Parameters.) ☐ Minimal; ☐ Low; ☐ Moderate; ☐ Serious; ☐ Extreme.

As Evidenced By:

- d. **Recipient Safety & Other Risk Factors:** ☐ Feels unsafe in current living environment; ☐ Feels currently being harmed/hurt/abused/threatened by someone; ☐ Engages in dangerous sexual behavior; ☐ Past involvement with Child or Adult Protective Services; ☐ Relapse/decompensation triggers; ☐ Other/Describe:

- e. Describe recipient's **preferences and desires** for addressing risk factors, including any Mental Health Advance Directives or plan of response to periods of decompensation/relapse (Ex. Resources recipient feels comfortable reaching out to for assistance in a crisis.):

# Medical History

## PHYSICAL/MEDICAL HISTORY

### V. CURRENT MEDICAL CONDITIONS (Check all that apply)

Meets Medical Eligibility for NF placement as determined by the Level I Authority ☐ Yes ☐ No

- |  |   |                                    |   |  |   |
|--|---|------------------------------------|---|--|---|
| <input type="checkbox"/> Pregnant            | Due date:   | Prenatal care:                     |   |  |   |
| <input type="checkbox"/> None Reported       | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Asthma    | <input type="checkbox"/> Seizure            | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Underweight              |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cirrhosis          | <input type="checkbox"/> Chronic Pain    | <input type="checkbox"/> Overweight               |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Sexually Transmitted Dz. |
| <input type="checkbox"/> Other/Describe:     |   |                                    |   |  |   |

### VI. CURRENT & PAST MEDICATIONS (Including non-psychotropic prescribed medications for last 12 months)

Medication Name	Dose	Freq.	Route	Current	COMMENTS (Reason Prescribed/Response/Side effects/Interactions, etc.)
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	
				<input type="checkbox"/> Yes; <input type="checkbox"/> No	

### VII. ALLERGIES ☐ No Reported Drug or Food Allergies; ☐ Other/Describe:

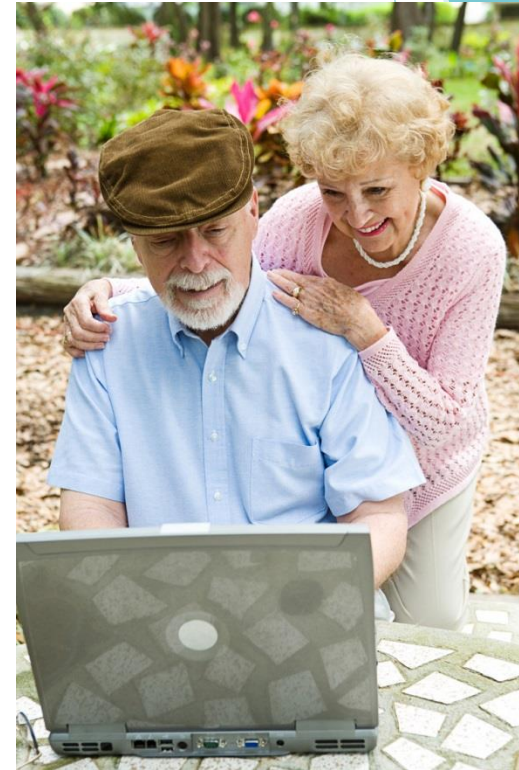
VIII. PRIMARY CARE PHYSICIAN	NAME	PHONE	FAX
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### IX. ADDITIONAL MEDICAL HISTORY (Diagnosis, Pertinent injuries (head trauma), Illnesses; Hospitalizations, Surgery, labs values, status of conditions, etc. including the dates of onset)

# Functional/Community Supports

*Least restrictive, most integrated choice*

- ▶ Communication
- ▶ Technology
- ▶ Functional/Medical protective care needs
- ▶ Supports needed to complete ADLS
- ▶ Supports needed to successfully live in the community
- ▶ Where do you want to live?
- ▶ With whom do you want to live?



- b. **Current Status & Functioning** (Assess ability to fulfill responsibilities, interact with others, capacity self-care, missed activities, work or school due to health, etc.)

Functional Status Impairment:

ADLs/IADLs	None	Minimal	Mild	Moderate	Serious	Extreme
Mobility						
Bathing						

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Dressing						
Self-Feeding						
Personal hygiene & grooming						
Toilet hygiene						
Housework						
Meal Preparation						
Medication Management						
Managing Finances						
Shopping (groceries or clothing)						
Communication						
Transportation						

Comments:

- c. **Abilities/Interests** - Include recipient reported skills, aptitudes, talents & competencies that may help maintain or improve socialization & community functioning.

#### IDENTIFIED NEEDS

1.

2.

3.

4.

5.

#### RECOMMENDED PLACEMENT

- ☐ The individual has a serious mental illness and requires specialized services in an **acute setting**. (i.e. acute psychiatric hospital)
- ☐ The individual has a serious mental illness and an **alternate setting** is recommended (i.e. community based treatment, adult residential facility) (specify setting)
- ☐ The individual has a serious mental illness and meets criteria for **nursing home admission**
  - ☐ **recommended on a long term basis**
  - ☐ **recommended on a short term basis** (specify duration)

# Placement Recommendations

## ► Regulations

- “According to the Code of Federal Regulations (CFR) 483.112, for each nursing facility (NF) applicant the state mental health authority must determine, in accordance with 483.130, whether, because the resident’s physical and mental condition, the individual requires the level of services provided by a NF. “
  - “The CFR 483.130 (m) states that any applicant for admission to a NF who has MI (mental illness) and does not require the level of services provided by a NF, regardless of whether specialized services are also needed, must not be admitted and cannot be considered appropriate for continued placement in a NF and must be discharged. “
- Appropriate only when meets minimum standards for admissions and treatment does not exceed level of services that can be provided by a NF.
- Less restrictive community options should also be considered.

# Placement Recommendations Cont'd

- ▶ Does the individual meet minimum criteria for NF placement/LOC?
- ▶ Does the individual require more intensive setting/services than what can be provided in the NF?
- ▶ Are there community supports to meet the individual's needs and would the individual be more appropriate in a less restrictive setting?

# Denials

- ▶ Does not require level of services for a NF.
  - doesn't need assistance with ADLS, 24 hour support for cognitive impairment not needed, and/or skilled nursing or rehabilitation services not needed.
- ▶ Needs can be met in a less restrictive environment.
  - applicant younger than NF population, doing well in previous community setting, and/or community supports are available.
- ▶ Needs exceed level of services provided by NF.
  - Psychiatrically not stable or potential risk to self or others.

### RECOMMENDED SPECIALIZED SERVICES (PROVIDED THROUGH MCO)

MH SERVICES:	<input type="checkbox"/> ACT	<input type="checkbox"/> CPST	<input type="checkbox"/> PSR -Individual	<input type="checkbox"/> PSR -Group	<input type="checkbox"/> PSH
	<input type="checkbox"/> Med Mgt	<input type="checkbox"/> Outpt Therapy (Ind)	<input type="checkbox"/> Outpt Therapy (Fam)	<input type="checkbox"/> Outpt Therapy (Group)	
SA SERVICES:	<input type="checkbox"/> Residential Tx	<input type="checkbox"/> Halfway House	<input type="checkbox"/> IOP	<input type="checkbox"/> Ambulatory Detox	
	<input type="checkbox"/> Outpt Therapy (Ind)	<input type="checkbox"/> Outpt Therapy (Fam)	<input type="checkbox"/> Outpt Therapy (Group)		
OTHER (WITH EXPLANATION)					

### RECOMMENDED LESSER SERVICES (PROVIDED OR ARRANGED BY THE NURSING FACILITY)

<input type="checkbox"/> Med Mgt by the NF	<input type="checkbox"/> Short term counseling to adjust to the nursing facility	<input type="checkbox"/> Medication education	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Training in ADLs	<input type="checkbox"/> Training in independent living skills
<input type="checkbox"/> Services for the visually/hearing impaired	<input type="checkbox"/> Assistance in obtaining medical appliances and devices	<input type="checkbox"/> Crisis intervention plan/safety plan	<input type="checkbox"/> Structured leisure activities	<input type="checkbox"/> Occupational therapy evaluation	<input type="checkbox"/> Physical therapy evaluation

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### PASRR LEVEL II INDEPENDENT BEHAVIORAL HEALTH COMPREHENSIVE EVALUATION

<input type="checkbox"/> Referrals to other agencies or community programs (please specify)	<input type="checkbox"/> <u>Audiological</u> evaluation	<input type="checkbox"/> Dental evaluation	<input type="checkbox"/> Vision evaluation	<input type="checkbox"/> Interpretive services	<input type="checkbox"/> A guardian / conservator for decisions regarding health and safety
<input type="checkbox"/> Evaluation for a diagnosis of dementia (Alzheimer's or other organic mental disorder)	<input type="checkbox"/> Ongoing evaluation of the effectiveness of current psychotropic medications to target symptoms.	<input type="checkbox"/> Other (with explanation)			

ADDITIONAL SERVICE RECOMMENDATIONS:

### INTERPRETATIVE SUMMARY OF FINDINGS/DECISION RATIONALE

*Describe recipient's global preferences/hopes for recovery, recommended treatments/assessments, level of care, duration. Include clinical/central theme, co-occurring disabilities (to include mental health, substance use, and intellectual/developmental disabilities), environmental and personal supports/needs, justification for placement and service recommendations.*

*Summarize findings regarding social, disability/psychiatric, medical and functional information.*

*Explain rationale & justification for placement decision and recommendations.*

# Where does the MCO send Level II evaluations?

- ▶ MCOs will email evaluations & documentation to OBH at [obh.pasrr@la.gov](mailto:obh.pasrr@la.gov)
  - Please include client initials in the subject line and PASRR Level II evaluation.
- ▶ MCOs have 4 calendar days to complete Level II evaluations

# Determination forms the MCO will receive from OBH following a determination

*MCOs will be faxed a copy of what is sent to the provider*

- ▶ Form 142: Authorization authenticating Medicaid payment and decision for NF (*sent to Medicaid & OAAS*)
- ▶ OBH Level II Evaluation Summary & Determination Notice
- ▶ Specialized Services Tracking form (*to be completed by NF and sent back to OBH*)

# What will the forms include?

- ▶ Recommendations for Nursing Home placement
- ▶ Length of time for Nursing Home placement
- ▶ Recommendations for Services
- ▶ Explanation of decisions
- ▶ Appeals Process

# MCOs role/responsibility in Specialized Behavioral Health Services (SS)

- ▶ Case Management for NF members identified by OBH as needing SS.
- ▶ Provides & Arranges for Behavioral Health Services
  - Includes arranging for Medicare services for dual-eligibles
- ▶ Tracking of individuals and services
- ▶ Consultants to NFs on behavioral health issues.
- ▶ Resources to NFs in discharge planning.

# Behavioral Health Services for Residents in NF

- ▶ Members residing in a NF have access to the full array of services noted in the BH Service Definition Manual.
- ▶ MHR services can be provided to eligible members

# MCOs role/responsibility in Tracking

- ▶ Independent evaluations
  - UM system for evaluators
  - Ensure Level II evaluations and determinations are done prior to admission and upon resident review.
- ▶ Determinations with specialized services
  - Case management and arranging of services
- ▶ Referrals and follow-up

# PASRR Contacts

# PASRR Contacts



► Medicaid, Mary Norris

225-342-1796

[mary.norris@la.gov](mailto:mary.norris@la.gov)

► OBH Level II PASRR Program

Main # 225-342-4827 [obh.pasrr@la.gov](mailto:obh.pasrr@la.gov)

Tara DeLee 225-342-4344 [tara.delee@la.gov](mailto:tara.delee@la.gov)

Fax# 1-877-652-4995

► OCDD Level II PASRR Program

Herman Bignar 225-342-8538 [herman.bignar@la.gov](mailto:herman.bignar@la.gov)

Dr. Amy Greer 225-342-0095 [amy.greer@la.gov](mailto:amy.greer@la.gov)

► OAAS, Linda Sadden

225-219-0214 [linda.sadden@la.gov](mailto:linda.sadden@la.gov)

# Helpful Sites

## ► MedlinePlus: Medical dictionary

- <http://www.nlm.nih.gov/medlineplus/mplusdictionary.html>

## ► Alzheimer's Association-diagnostic procedures for dementia

- [http://www.alz.org/professionals\\_and\\_researchers\\_diagnostic\\_procedures.as](http://www.alz.org/professionals_and_researchers_diagnostic_procedures.as)

## ► MDS

- <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html>

## ► PHQ9

- [http://cqaimh.org/pdf/tool\\_phq9.pdf](http://cqaimh.org/pdf/tool_phq9.pdf)

## ► BIMS

- [http://dhmh.dfmc.org/longTermCare/documents/BIMS\\_Form\\_Instructions.pdf](http://dhmh.dfmc.org/longTermCare/documents/BIMS_Form_Instructions.pdf)

# PASRR Websites and Information

- ▶ CMS PASRR technical assistance center

- [www.pasrrassist.org](http://www.pasrrassist.org)

- ▶ *LOCET Training & Info-OAAS*

- <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2327>

# QUESTIONS & COMMENTS

## Information needed from MCOs:

- PASRR Points of Contact & Contact Information
  - Email Addresses
  - Telephone Numbers
  - PASRR Fax Numbers
- Member & NF Points of Contact
  - Telephone Numbers
  - Website

