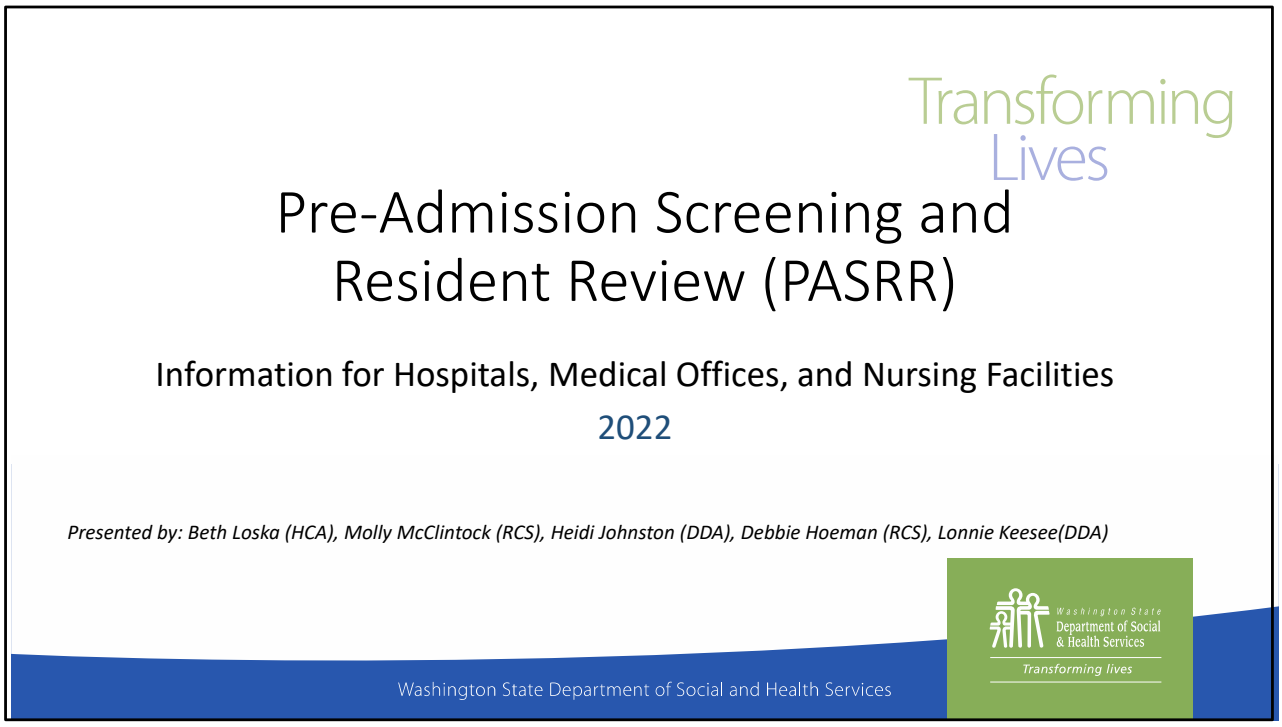
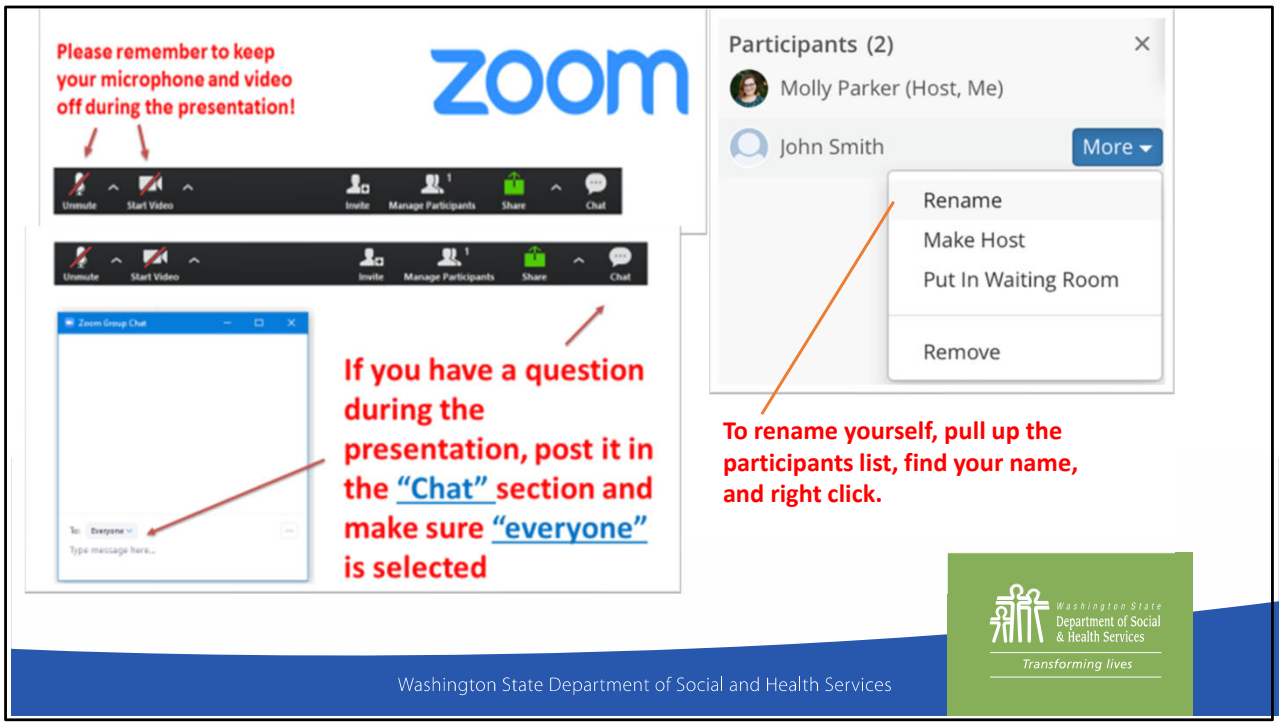


BL

We see there are members still joining the call, so we will begin our presentation in a few minutes.

Hello and Welcome to the PASRR webinar this Morning. My name is Beth Loska and I am the Behavioral Health PASRR Program Manager with WA Health Care Authority. Let's get started!



Service Alternatives presents this information.

Neetu, Ali, or Martin

Introduction

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So you know who is with us today ,all presenters will now introduce themselves.

Hello! I'm Molly McClintock, from Residential Care Services. I am the Nursing Home Policy Program Manager.

Hi, I am Debbie Hoeman, Behavioral Health Policy Program Manager, with Residential Care Services.

Hi, I am Heidi Johnston, PASRR Program Manager with the Developmental Disabilities Administration.

Hello! I'm Lonnie Keesee, PASRR Unit Manager for the Developmental Disabilities Administration.

For Your Information …

- Today's webinar will focus on the role of hospitals and nursing facilities in the PASRR process, person-centered practices and integrated care.

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We hold PASRR webinars annually. With us today we have skilled nursing facilities, hospitals, DSHS staff (DDA, HCA, ALTSA) and HCA contractors.

The PASRR process here in Washington continues to grow and be refined. We plan to continue with periodic updates.

Also important to note, that a resident who has a positive PASRR may have multiple case workers who are working with them. It is not unusual for this to occur, so we don't want anyone to be surprised if this happens in their facility. **ADDITIONALLY, THERE ARE TWO SEPARATE PASRR PROGRAMS: DDA PASRR for people with Intellectual Disabilities and Related Condition and Behavioral Health PASRR. When applicable, differences in the two programs will be highlighted.**

Regulations Related to PASRR

Both the federal government and the State of Washington regulate PASRR.

- The federal rules related to PASRR can be found at: 42 C.F.R. 483.100 - 483.138 (Note: an annual PASRR is no longer required but Code of Federal Regulation has not been revised to reflect this change.)
- Washington Administrative Code addresses PASRR in two sections: 388-97-1910 through 388-97-2000 and Section 388-834.

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MM –
Hello, first I'd like to clarify the PASRR abbreviations. You might sometimes see Pre-Admission Screening and Resident Review abbreviated as P-A-S-R-R and sometimes it is spelled P-A-S-A-R-R. The two acronyms are used interchangeably. The federal rules formerly required an annual review and the second "A" in the P-A-S-A-R-R spelling stood for "annual."

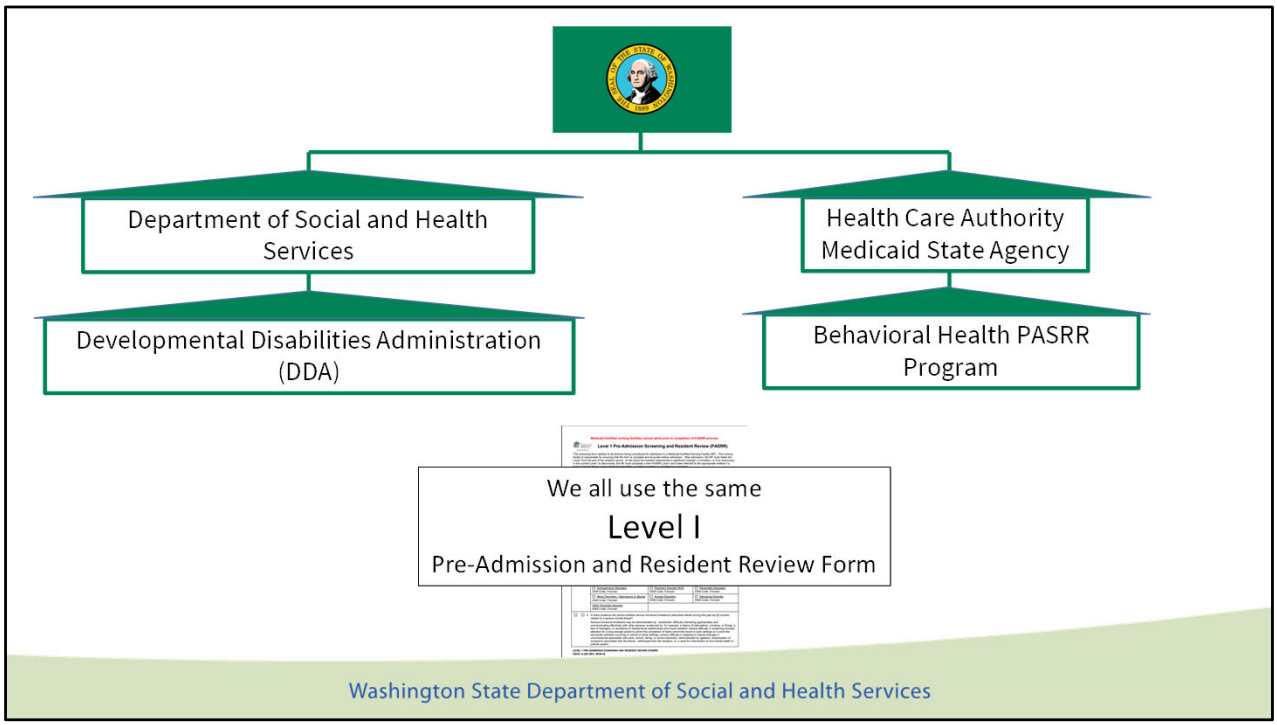
The requirement for an annual assessment was discontinued in 1996, though the Code of Federal Regulations, or CFRs, have not been updated to reflect the change.

So, a new PASRR is not required annually, but is required whenever a resident with Serious Mental Illness (SMI) or Intellectual Disability or Related Condition (ID/RC) experiences a significant change in condition, or if a resident is newly identified as having a SMI or ID/RC. Additionally, Developmental Disabilities Administration (DDA) completes follow-up evaluations for people who remain in a Nursing Facility longer than 90 days.

For your reference, this slide shows the federal and state rules related to PASRR.

- For Washington State, rules are found in the Washington Administrative Code, known as WACs. For Nursing home specific rules, look at 388-97-1910 through 388-97-2000. Rules specifically related to Developmental Disabilities are at 388-834.

- The federal regulation is found at 42 CFR 483.100 through 483.138. The guidance for those rules is found in Appendix PP, at F644 and F645.



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PASRR Is a federal program, however, in Washington state, the responsibilities for PASRR are divided among different Agency's. The Department of Social and Health Services administers their PASRR Program through the Developmental Disability Administration (DDA). The Health Care Authority administers the BH PASRR Program.

If a client has both an Intellectual Disability or Related Condition and Serious Mental Illness concern, the Level I PASRR evaluation should be completed and sent to BOTH DDA and BH PASRR. Please direct your questions regarding Intellectual Disabilities and Related Conditions to DDA and your Serious Mental Illness questions to HCA.

Both sections of PASRR utilize the same Level I PASRR Pre-Admission and Resident Review Form, but there are a few key differences that are worth noting.

The DDA's PASRR Program is

- Staffed by state employees
- Able to return to the facilities for regularly scheduled Follow-up
- Most recommended services are arranged by DDA

The BH PASRR Program

- Delegates authority to Contractors
- These contractors only return to facilities after the initial screening to due to a Significant Change in Condition or need for Follow-up
- Recommended services are coordinated through Medicaid by the Skilled Nursing Facility

What does PASRR do?

PASRR has three goals:

- To identify people referred to nursing facilities who have an intellectual disability or related condition (ID/RC) or a serious mental illness (SMI);
- To determine that individuals are admitted appropriately; and
- To make sure individuals receive the services they need for ID/RC or SMI.

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PASRR has three goals:

The first goal of PASRR is to **identify** people referred to nursing facilities who have an intellectual disability or related condition (ID/RC) or a serious mental illness (SMI);

The second goal is to ensure that the individuals with the serious mental illness, Intellectual disability or related condition are admitted appropriately. This means the person is admitted in a home that is the **least restrictive setting** that still meets their particular care needs.

The third goal of PASRR is for each person identified through the PASRR process to receive the services they need, if they are identified as needing services. The services I'm describing are services that are specific to their serious mental illness or intellectual disability or related condition.

Why is PASRR Important?

According to *Medicaid.gov*:

"PASRR can advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care".

PASRR can enhance nursing facility (NF) care by providing additional disability-related services not included in the NF daily rate and by making recommendations to the NF.

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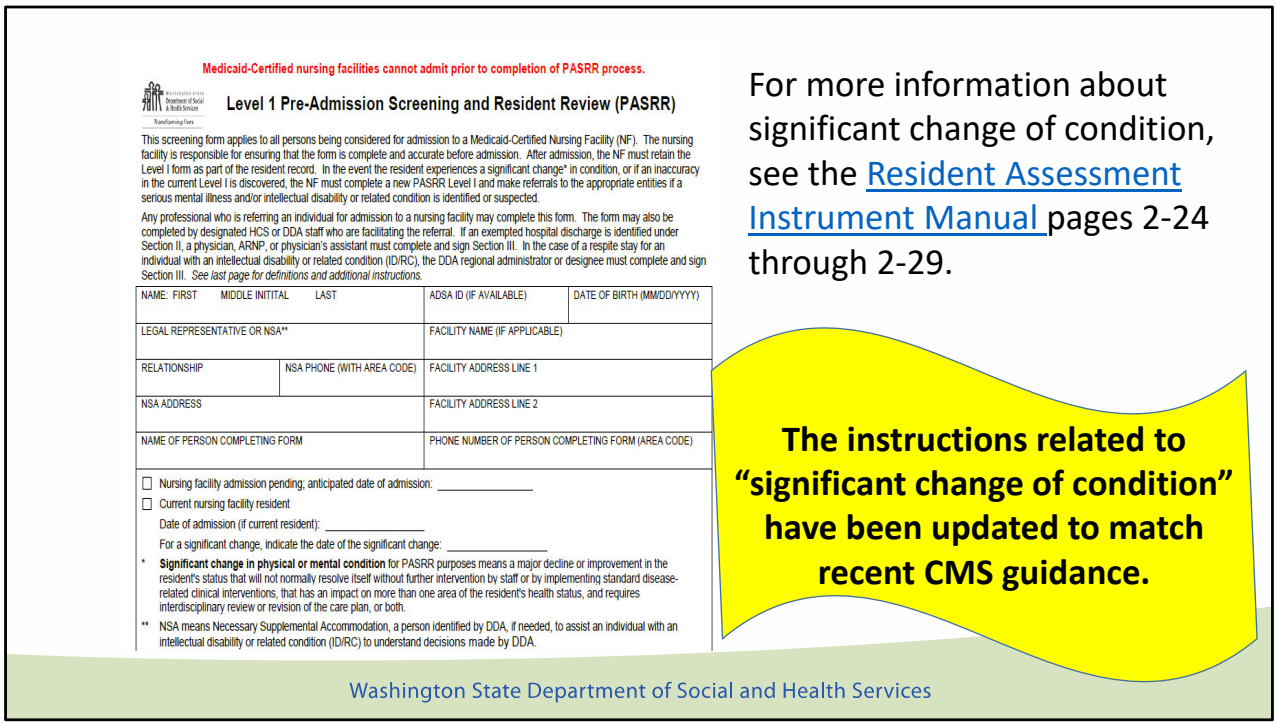
So, why is PASRR important?

PASRR can improve the quality of life for residents with Significant Mental Illness or Intellectual disability/Related Condition. PASRR advances person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long term care. It also helps assure care is done in the least restrictive setting.

PASRR can enhance nursing facility care by providing additional disability-related services not included in the NF daily rate and by making recommendations to the nursing facility.

So, not only is the PASRR process important to ensure people with SMI or ID receive care in the least restrictive setting, it also provides evaluation and services to help ensure appropriate care is provided in a dignified and person-centered manner to those who reside at a nursing facility.



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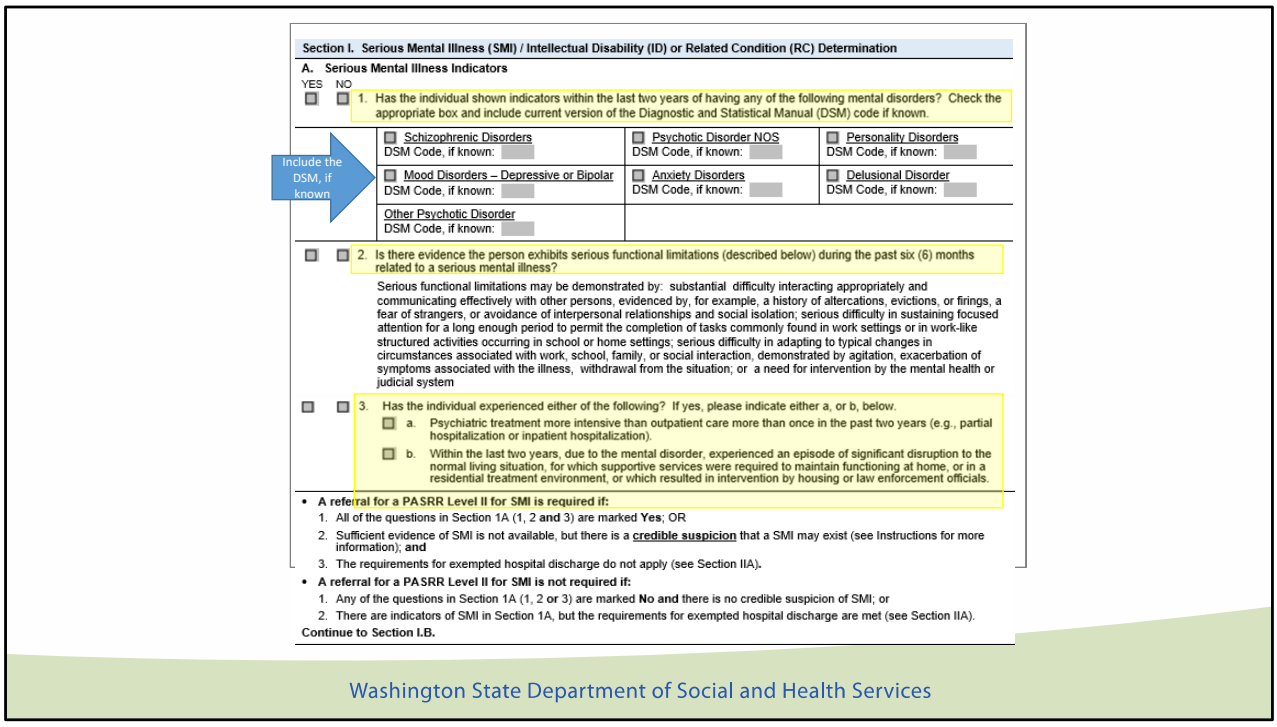
Level I is completed by the referring party – usually a hospital or community medical office. For those completing Level 1's, please fill out the entire first section with all information available.

Level II is completed by the behavioral health or intellectual disability PASRR evaluator – or both, if dually diagnosed.

For more information about significant change of condition, see the Resident Assessment Instrument Manual pages 2-24 through 2-29. The instructions related to "Significant Change of Condition" have been updated to match recent CMS guidance.,



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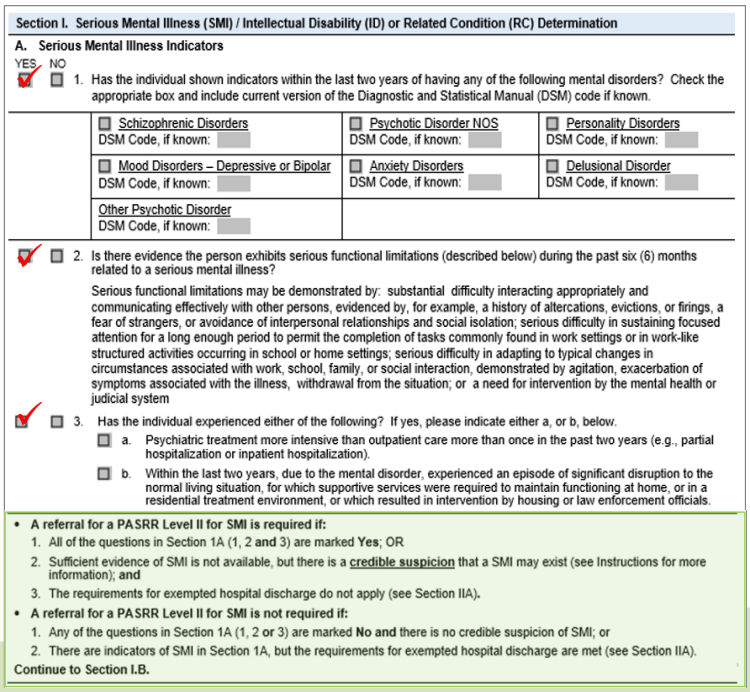
Please read the form carefully and provide as much information as possible to assist the evaluator.

- If an individual has all three indicators: Refer to PASRR.
- If an individual does NOT have all three indicators, but you believe the individual may have SMI: Refer to PASRR.
- The same criteria is used for a significant change.
- **For SMI (only)**, a referral for Level II is not required if all the criteria for Exempted Hospital Discharge are met and the stay is less than 30 days.



Section I. Serious Mental Illness (SMI) / Intellectual Disability (ID) or Related Condition (RC) Determination

A. Serious Mental Illness Indicators

YES ☑ NO ☐ 1. Has the individual shown indicators within the last two years of having any of the following mental disorders? Check the appropriate box and include current version of the Diagnostic and Statistical Manual (DSM) code if known.

☐ Schizophrenic Disorders DSM Code, if known:	☐ Psychotic Disorder NOS DSM Code, if known:	☐ Personality Disorders DSM Code, if known:
☐ Mood Disorders – Depressive or Bipolar DSM Code, if known:	☐ Anxiety Disorders DSM Code, if known:	☐ Delusional Disorder DSM Code, if known:
☐ Other Psychotic Disorder DSM Code, if known:		

☑ ☐ 2. Is there evidence the person exhibits serious functional limitations (described below) during the past six (6) months related to a serious mental illness?

Serious functional limitations may be demonstrated by: substantial difficulty interacting appropriately and communicating effectively with other persons, evidenced by, for example, a history of altercations, evictions, or firings, a fear of strangers, or avoidance of interpersonal relationships and social isolation; serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings; serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, demonstrated by agitation, exacerbation of symptoms associated with the illness, withdrawal from the situation; or a need for intervention by the mental health or judicial system

☑ ☐ 3. Has the individual experienced either of the following? If yes, please indicate either a, or b, below.

☐ a. Psychiatric treatment more intensive than outpatient care more than once in the past two years (e.g., partial hospitalization or inpatient hospitalization).

☐ b. Within the last two years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

- **A referral for a PASRR Level II for SMI is required if:**
  1. All of the questions in Section 1A (1, 2 **and** 3) are marked **Yes**; OR
  2. Sufficient evidence of SMI is not available, but there is a **credible suspicion** that a SMI may exist (see Instructions for more information); **and**
  3. The requirements for exempted hospital discharge do not apply (see Section IIA).
- **A referral for a PASRR Level II for SMI is not required if:**
  1. Any of the questions in Section 1A (1, 2 **or** 3) are marked **No and** there is no credible suspicion of SMI; or
  2. There are indicators of SMI in Section 1A, but the requirements for exempted hospital discharge are met (see Section IIA).

Continue to Section I.B.

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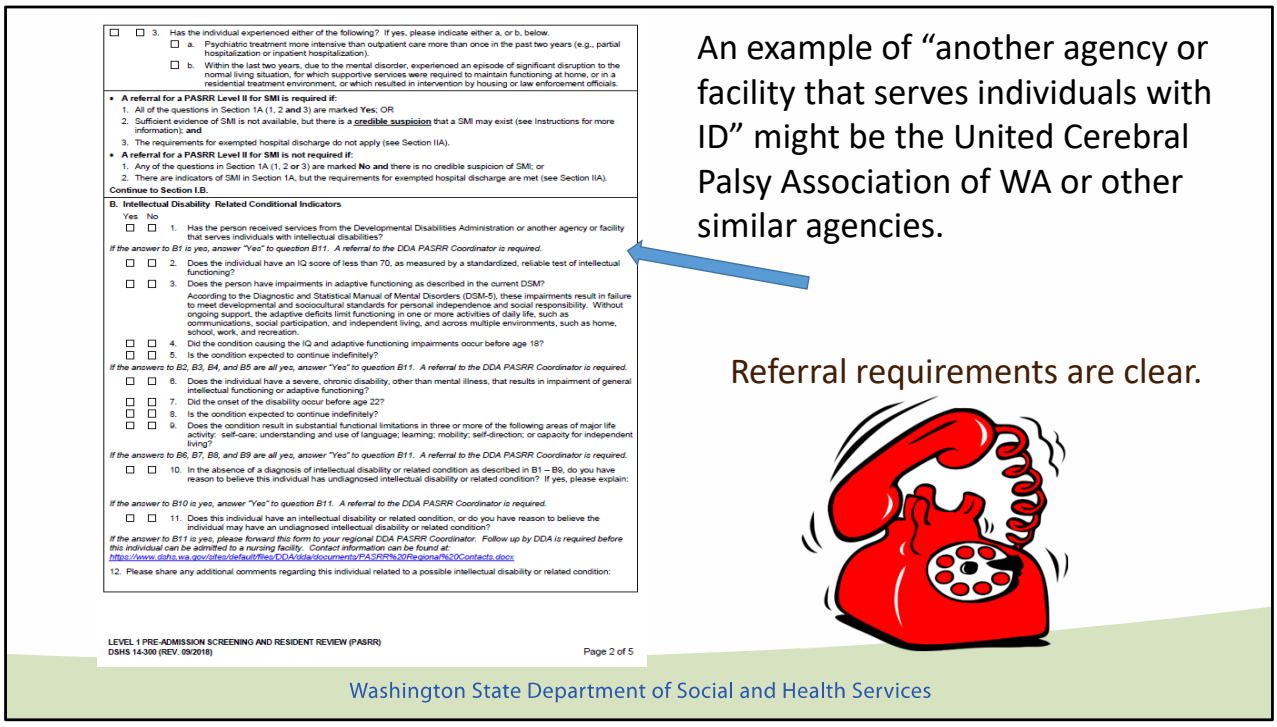
If an individual has all three indicators: Refer for PASRR

If an individual does not have all three indicators, but you believe the individual may have SMI: Refer for PASRR

The same criteria is used for a significant change.

For SMI (only), a referral for Level II is not required if all the criteria for Exempted Hospital Discharge are met and the stay is less than 30 days.



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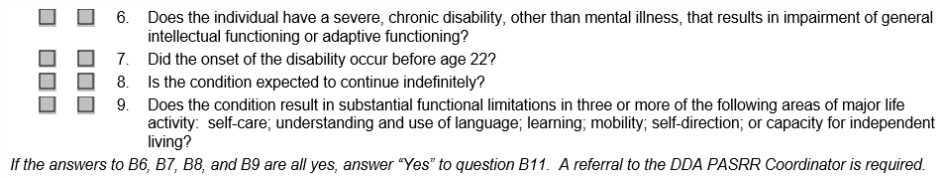
- In section B, the referring party determines whether the individual should be referred to the DDA PASRR team for possible intellectual disability or related condition.
- There are 4 ways a person qualifies to be referred to DDA.
- If the person is a DDA client, answer "yes" to question #1. After answering "yes" to #1, jump down to #11 **(**Answer "yes" there also, and refer. Question 11 is always answered yes if the person is being referred to the DDA PASRR team.
- If the person isn't a DDA client, or if you're unsure, answer questions 2-5. If there's no evidence that an answer is "yes", the question should be answered "no". If the answers to 2 – 5 are **all** "yes," then the person qualifies for referral under intellectual disability (or ID). Answer yes to #11, and refer to DDA.
- If the person hasn't qualified as a DDA client or under ID, complete questions 6-9 to see if the person should be referred under related condition (or RC). Those questions are: If all the answers in this section are "yes", answer "yes" to #11 and make the referral.
- If you haven't referred the person as a DDA client, or as a person believed to have ID or RC – intellectual disability or related condition – but you still have reason to believe one of these conditions may exist, answer "yes" to questions #10 and #11 and refer. If you answered yes to #10 –- explain what leads you to this conclusion.
- Question 12 is optional. If you have additional information that may be useful to the

PASRR assessor, please enter it here.

Clarification About "Related Condition"



☐ ☐ 6. Does the individual have a severe, chronic disability, other than mental illness, that results in impairment of general intellectual functioning or adaptive functioning?
☐ ☐ 7. Did the onset of the disability occur before age 22?
☐ ☐ 8. Is the condition expected to continue indefinitely?
☐ ☐ 9. Does the condition result in substantial functional limitations in three or more of the following areas of major life activity: self-care; understanding and use of language; learning; mobility; self-direction; or capacity for independent living?

If the answers to B6, B7, B8, and B9 are all yes, answer "Yes" to question B11. A referral to the DDA PASRR Coordinator is required.

- The form makes it clear that functional limitations alone *do not* necessitate a referral.
- Functional deficits must be attributable to a severe disability which occurred prior to age 22 and is expected to continue indefinitely.
- This includes TBI, stroke, etc. If in doubt, refer.

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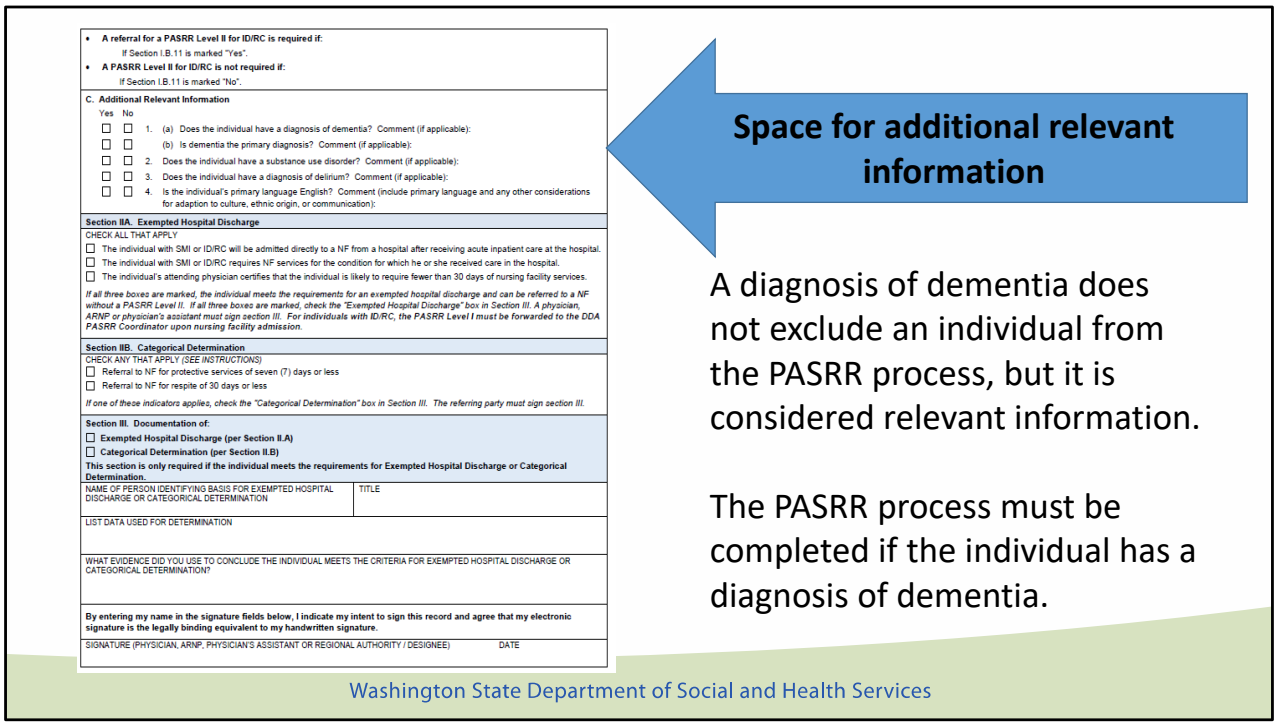
Occasionally, we get a referral for someone who had mostly "yes" answers here but at least one question was "no". For example, a person who experienced a traumatic brain injury may have a disability that causes functional limitations similar to a person with intellectual disability, and it may be expected to continue for life, but if the TBI occurred at age 40, this is NOT a related condition. If it occurred at age 20, all questions would be answered "yes" and the person should be referred. If you don't know when the TBI occurred, you may refer this person by answering "yes" to question # 10, the one about having reason to believe the person has ID/RC in the absence of conclusive evidence.



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Section C should be completed with any relevant information available to you. These questions are helpful for staff at the nursing facility where the person is being referred, and also for the PASRR team.

What about people who are going to a NF for short-term rehab after hospital treatment?

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- PA, ARNP, etc.
Signatures can be electronic.

ADDED NOTES:
Some people with ID/RC or SMI don't need to be assessed by DDA or HCA prior to NF admission. These cases are called Exempted Hospital Discharge (EHDs).
To qualify as an EHD, three things must be true:

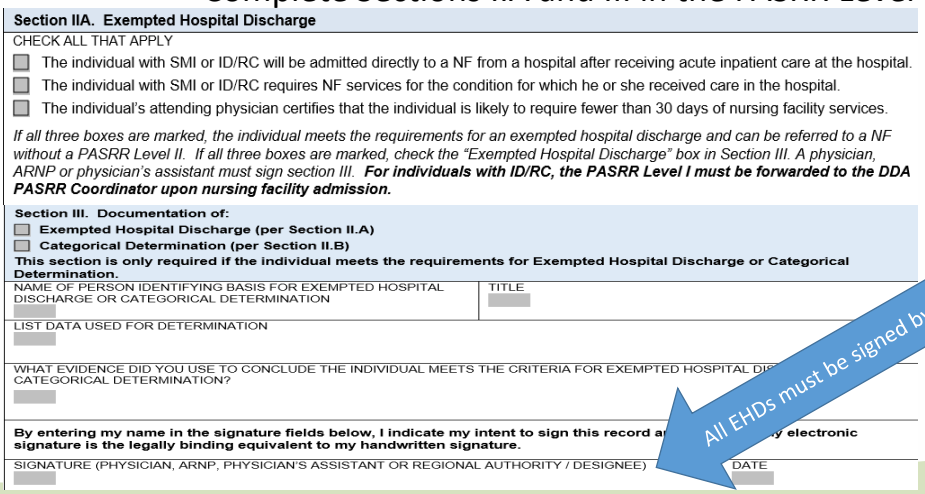
- ✓The person will go directly from a hospital to the NF;
- ✓The person will be treated for the same condition in the NF as

they were treated for in the hospital; and

- ✓The treating physician certifies in writing that the NF stay is expected to last less than 30 days.
  - ❖The signature can be electronic (see form for detail)

How does the hospital designate an Exempted Hospital Discharge?

Complete Sections IIA and III in the PASRR Level I



Section IIA. Exempted Hospital Discharge

CHECK ALL THAT APPLY

- ☐ The individual with SMI or ID/RC will be admitted directly to a NF from a hospital after receiving acute inpatient care at the hospital.
- ☐ The individual with SMI or ID/RC requires NF services for the condition for which he or she received care in the hospital.
- ☐ The individual's attending physician certifies that the individual is likely to require fewer than 30 days of nursing facility services.

If all three boxes are marked, the individual meets the requirements for an exempted hospital discharge and can be referred to a NF without a PASRR Level II. If all three boxes are marked, check the "Exempted Hospital Discharge" box in Section III. A physician, ARNP or physician's assistant must sign section III. ***For individuals with ID/RC, the PASRR Level I must be forwarded to the DDA PASRR Coordinator upon nursing facility admission.***

Section III. Documentation of:

- ☐ **Exempted Hospital Discharge (per Section II.A)**
- ☐ **Categorical Determination (per Section II.B)**

This section is only required if the individual meets the requirements for Exempted Hospital Discharge or Categorical Determination.

NAME OF PERSON IDENTIFYING BASIS FOR EXEMPTED HOSPITAL DISCHARGE OR CATEGORICAL DETERMINATION	TITLE

LIST DATA USED FOR DETERMINATION

WHAT EVIDENCE DID YOU USE TO CONCLUDE THE INDIVIDUAL MEETS THE CRITERIA FOR EXEMPTED HOSPITAL DI… CATEGORICAL DETERMINATION?

By entering my name in the signature fields below, I indicate my intent to sign this record a… …y electronic signature is the legally binding equivalent to my handwritten signature.

SIGNATURE (PHYSICIAN, ARNP, PHYSICIAN'S ASSISTANT OR REGIONAL AUTHORITY / DESIGNEE) DATE

All EHDs must be signed by physician, PA, or ARNP.

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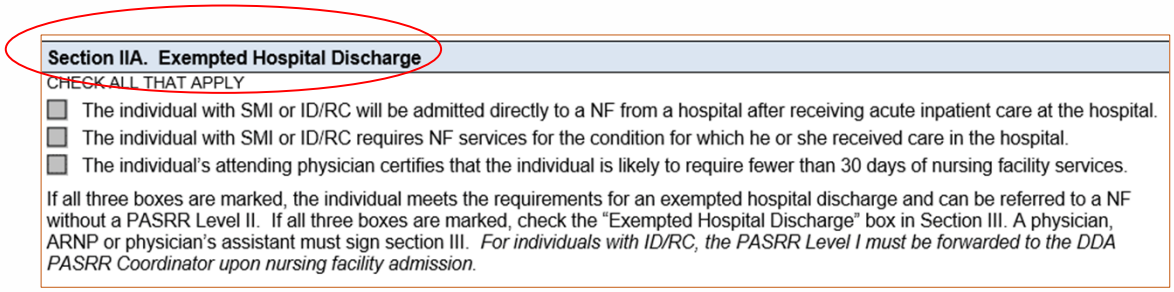
- Section 2A is used to indicate an exempted hospital discharge.
- Note that all 3 boxes at the top of this section must be checked to indicate exempted hospital discharge.
- In section 3, check exempted hospital discharge.
- The name and signature block refers to the treating professional – dr., Physician's Assistant or Advanced Registered Nurse Practitioner
- If ID/RC indicators are present, send completed L1 to your DDA PASRR team.
- Keep in mind, NFs and PASRR evaluators have been asked to report hospitals to DOH if a hospital demonstrates a pattern of EHD when > 30 days

What happens if a person entered the facility on an EHD, but the stay later extends beyond 30 days and the person does not meet PASRR Level II criteria?



Section IIA. Exempted Hospital Discharge

CHECK ALL THAT APPLY

- ☐ The individual with SMI or ID/RC will be admitted directly to a NF from a hospital after receiving acute inpatient care at the hospital.
- ☐ The individual with SMI or ID/RC requires NF services for the condition for which he or she received care in the hospital.
- ☐ The individual's attending physician certifies that the individual is likely to require fewer than 30 days of nursing facility services.

If all three boxes are marked, the individual meets the requirements for an exempted hospital discharge and can be referred to a NF without a PASRR Level II. If all three boxes are marked, check the "Exempted Hospital Discharge" box in Section III. A physician, ARNP or physician's assistant must sign section III. *For individuals with ID/RC, the PASRR Level I must be forwarded to the DDA PASRR Coordinator upon nursing facility admission.*

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If the person doesn't have indicators of ID/RC or SMI, skip this section.

If person admits under EHD, contact PASRR rep as soon as you become aware the stay may extend beyond 30 days.
This should be rare since the treating professional is certifying in writing that the person is expected to need treatment for 30 days or less.
The NF is responsible to contact the PASRR team as soon as they become aware the stay may last longer than 30 days. A facility can be cited if the Level I on file is for an exempted hospital discharge but the admit date is more than 30 days in the past.

ADDED NOTES:

- If the individuals meets all the criteria for an EHD, a physician, ARNP or PA is required to sign the section regarding EHD.
- If an individual admitted on an EHD and the stay extends beyond 30 days, the SNF is responsible to notify the PASRR assessor.

What about people who admit to the NF for a respite stay?

- For individuals with ID/RC, the DDA PASRR Assessor typically completes the Level I.
- Contact the regional PASRR Coordinator if you wish to refer someone to a NF for respite (a Regional DDA Authority or designee will sign section III).
- Respite admissions must be 30 days or less (allowed: 30 total days over the course of 1 year).

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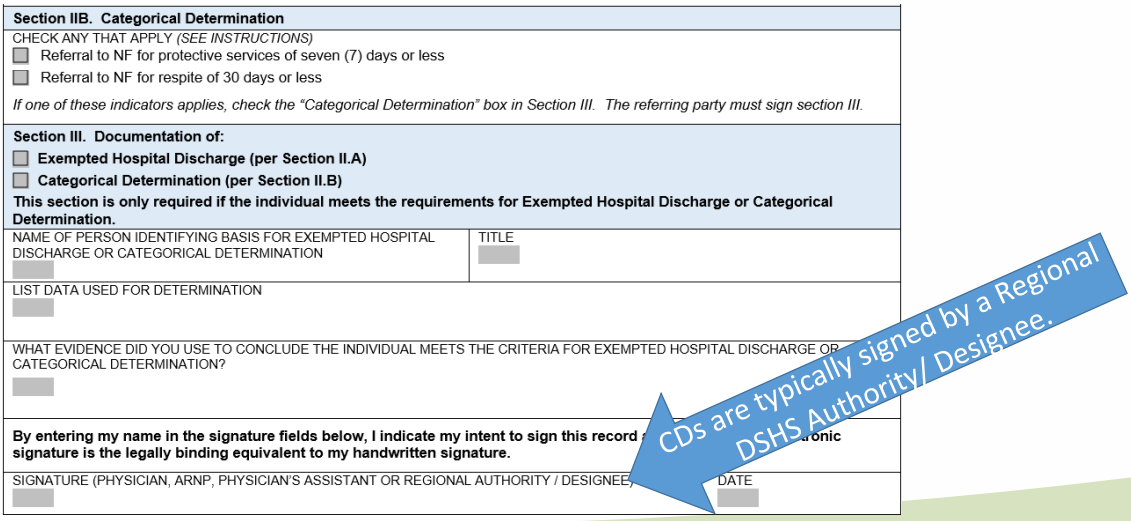
- For individuals with ID/RC, the DDA PASRR Assessor completes the Level I.
- A physician's office should contact the regional PASRR Coordinator if you wish to refer someone to a NF for respite (PASRR staff will sign section III).
- Note that PASRR staff doesn't refer people for NF care, but they are required to complete a L1 before respite can occur.
- Respite admissions must be 30 days or less (allowed: 30 total days over the course of 1 year).

What is a Categorical Determination?



Section IIB. Categorical Determination

CHECK ANY THAT APPLY *(SEE INSTRUCTIONS)*

- ☐ Referral to NF for protective services of seven (7) days or less
- ☐ Referral to NF for respite of 30 days or less

If one of these indicators applies, check the "Categorical Determination" box in Section III. The referring party must sign section III.

Section III. Documentation of:

- ☐ **Exempted Hospital Discharge (per Section II.A)**
- ☐ **Categorical Determination (per Section II.B)**

This section is only required if the individual meets the requirements for Exempted Hospital Discharge or Categorical Determination.

NAME OF PERSON IDENTIFYING BASIS FOR EXEMPTED HOSPITAL DISCHARGE OR CATEGORICAL DETERMINATION	TITLE

LIST DATA USED FOR DETERMINATION

WHAT EVIDENCE DID YOU USE TO CONCLUDE THE INDIVIDUAL MEETS THE CRITERIA FOR EXEMPTED HOSPITAL DISCHARGE OR CATEGORICAL DETERMINATION?

By entering my name in the signature fields below, I indicate my intent to sign this record ... signature is the legally binding equivalent to my handwritten signature.

SIGNATURE (PHYSICIAN, ARNP, PHYSICIAN'S ASSISTANT OR REGIONAL AUTHORITY / DESIGNEE) DATE

CDs are typically signed by a Regional DSHS Authority/ Designee.

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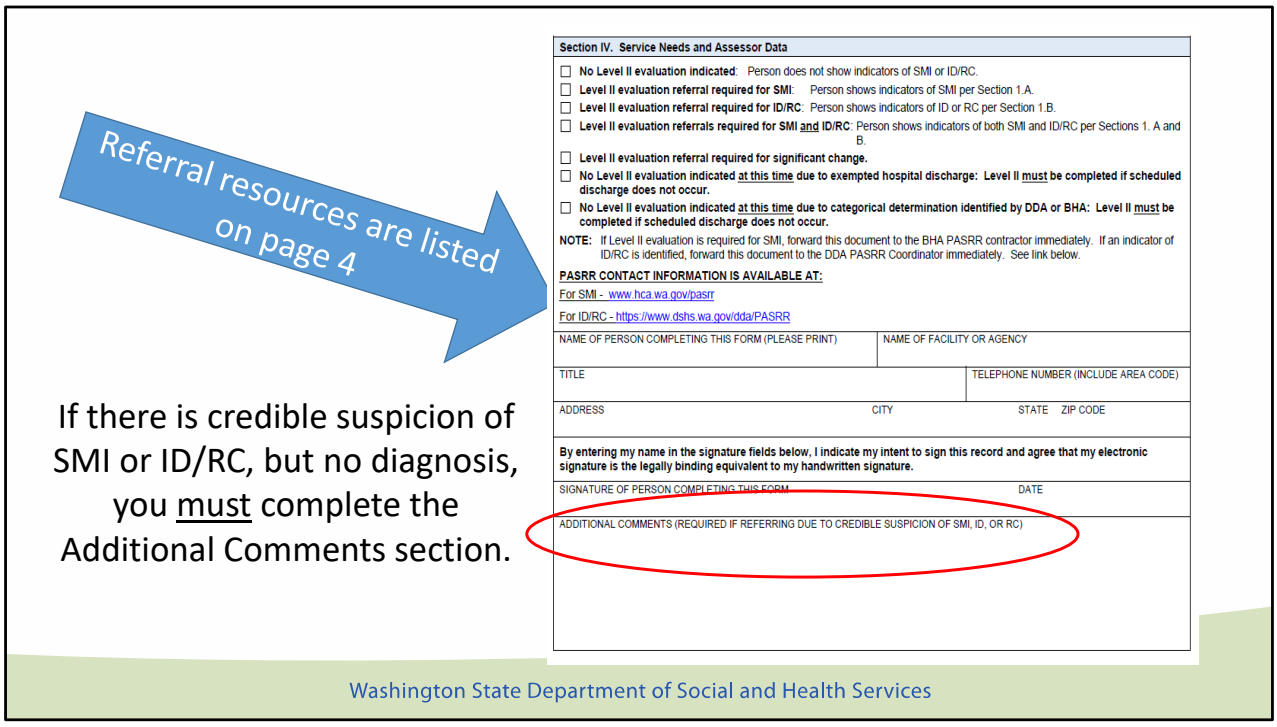
- A respite admission for a person with intellectual disability, related condition, or serious mental illness results in a categorical determination.
- Most determinations made by a PASRR assessor are done individually, by interviews and record gathering. For respites of 30 days or less, PASRR may **categorically** determine that specialized disability services are not needed.
- The reason for deciding this categorically is that people who are on short term respite generally won't be admitted long enough to benefit from a specialized service.
- The authority to make a categorical determination is established in the Medicaid state plan.



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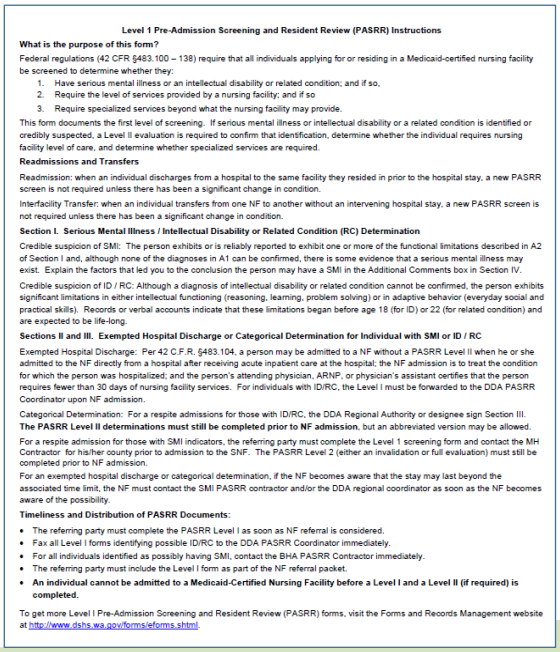
Section 4 questions are for summarizing your findings and then direct you to the BH & DDA Contact information.

Be sure your information is consistent through out the form.

The “Additional Comments” section is where you document your creditable suspicion of SMI, ID/RC.

The last page contains additional information.

Many of your questions are answered here.



Level 1 Pre-Admission Screening and Resident Review (PASRR) Instructions

What is the purpose of this form?

Federal regulations (42 CFR §483.100 – 138) require that all individuals applying for or residing in a Medicaid-certified nursing facility be screened to determine whether they:

1. Have serious mental illness or an intellectual disability or related condition; and if so,
2. Require the level of services provided by a nursing facility; and if so
3. Require specialized services beyond what the nursing facility may provide.

This form documents the first level of screening. If serious mental illness or intellectual disability or a related condition is identified or credibly suspected, a Level II evaluation is required to confirm that identification, determine whether the individual requires nursing facility level of care, and determine whether specialized services are required.

Readmissions and Transfers

Readmission: when an individual discharges from a hospital to the same facility they resided in prior to the hospital stay, a new PASRR screen is not required unless there has been a significant change in condition.

Interfacility Transfer: when an individual transfers from one NF to another without an intervening hospital stay, a new PASRR screen is not required unless there has been a significant change in condition.

Section I. Serious Mental Illness / Intellectual Disability or Related Condition (RC) Determination

Credible suspicion of SMI: The person exhibits or is reliably reported to exhibit one or more of the functional limitations described in A2 of Section I and, although none of the diagnoses in A1 can be confirmed, there is some evidence that a serious mental illness may exist. Explain the factors that led you to the conclusion the person may have a SMI in the Additional Comments box in Section IV.

Credible suspicion of ID / RC: Although a diagnosis of intellectual disability or related condition cannot be confirmed, the person exhibits significant limitations in either intellectual functioning (reasoning, learning, problem solving) or in adaptive behavior (everyday social and practical skills). Records or verbal accounts indicate that these limitations began before age 18 (for ID) or 22 (for related condition) and are expected to be life-long.

Sections II and III. Exempted Hospital Discharge or Categorical Determination for Individual with SMI or ID / RC

Exempted Hospital Discharge: Per 42 C.F.R. §483.104, a person may be admitted to a NF without a PASRR Level II when he or she admitted to the NF directly from a hospital after receiving acute inpatient care at the hospital; the NF admission is to treat the condition for which the person was hospitalized; and the person's attending physician, ARNP, or physician's assistant certifies that the person requires fewer than 30 days of nursing facility services. For individuals with ID/RC, the Level I must be forwarded to the DDA PASRR Coordinator upon NF admission.

Categorical Determination: For a respite admissions for those with ID/RC, the DDA Regional Authority or designee sign Section III. **The PASRR Level II determinations must still be completed prior to NF admission**, but an abbreviated version may be allowed.

For a respite admission for those with SMI indicators, the referring party must complete the Level 1 screening form and contact the MH Contractor for his/her county prior to admission to the SNF. The PASRR Level 2 (either an invalidation or full evaluation) must still be completed prior to NF admission.

For an exempted hospital discharge or categorical determination, if the NF becomes aware that the stay may last beyond the associated time limit, the NF must contact the SMI PASRR contractor and/or the DDA regional coordinator as soon as the NF becomes aware of the possibility.

Timeliness and Distribution of PASRR Documents:

- The referring party must complete the PASRR Level I as soon as NF referral is considered.
- Fax all Level I forms identifying possible ID/RC to the DDA PASRR Coordinator immediately.
- For all individuals identified as possibly having SMI, contact the BHA PASRR Contractor immediately.
- The referring party must include the Level I form as part of the NF referral packet.
- **An individual cannot be admitted to a Medicaid-Certified Nursing Facility before a Level I and a Level II (if required) is completed.**

To get more Level I Pre-Admission Screening and Resident Review (PASRR) forms, visit the Forms and Records Management website at http://www.dshs.wa.gov/forms/eforms.shtml.

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LK

The last page of the PASRR Level I contains additional Information. You may find answers to your questions here.

COVID-19 related PASRR Timelines

- In March 2020, Washington received CMS approval of an 1135 waiver that impacts PASRR timelines.
- This waiver allows that PASRR Level 1 and Level 2 assessments not be required for 30 days after admission.

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In March 2020, Washington received CMS approval of an 1135 waiver that impacts PASRR timelines. An administrator letter was issued related to the waiver, but it appears some facilities remain confused about what the waiver does, and does not, mean.

This waiver allows that PASRR Level 1 and Level 2 assessments not be required for 30 days after admission.

Note that the state rules were changed to agree with the federal rules.

It is advantageous for the resident and facility to complete the Level 1's as soon as possible to ensure services are obtained as soon as possible. It helps the facility to have the Level 1 completed as soon as possible to ensure required comprehensive assessments are completed timely.

What the 1135 Waiver Means:

- A person may be admitted to a nursing facility *without* having a Level 1 or Level 2 PASRR prior to the admission.
- The requirement is waived for an individual admission for 30 days.
- The nursing home bears the responsibility to track such admissions and obtain a Level 1 and Level 2 (if indicated) when the 30 days has expired.
- A facility could be cited for failing to obtain a PASRR Level 1 and (if indicated) a Level 2 after 30 days of residency.
- If the hospital or nursing facility submits a Level 1 prior to or upon admission, PASRR will be responsible for completing the Level 2 as required.

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- **A person may be admitted to a nursing facility *without* having a Level 1 or Level 2 PASRR prior to the admission.**
- **The requirement is waived for an individual admission for 30 days.**

The waiver allows postponement of the PASRR process for any individual for 30 days. It does not REQUIRE postponement. There is nothing prohibiting hospitals and nursing facility staff from following the regular timelines for PASRR completion.

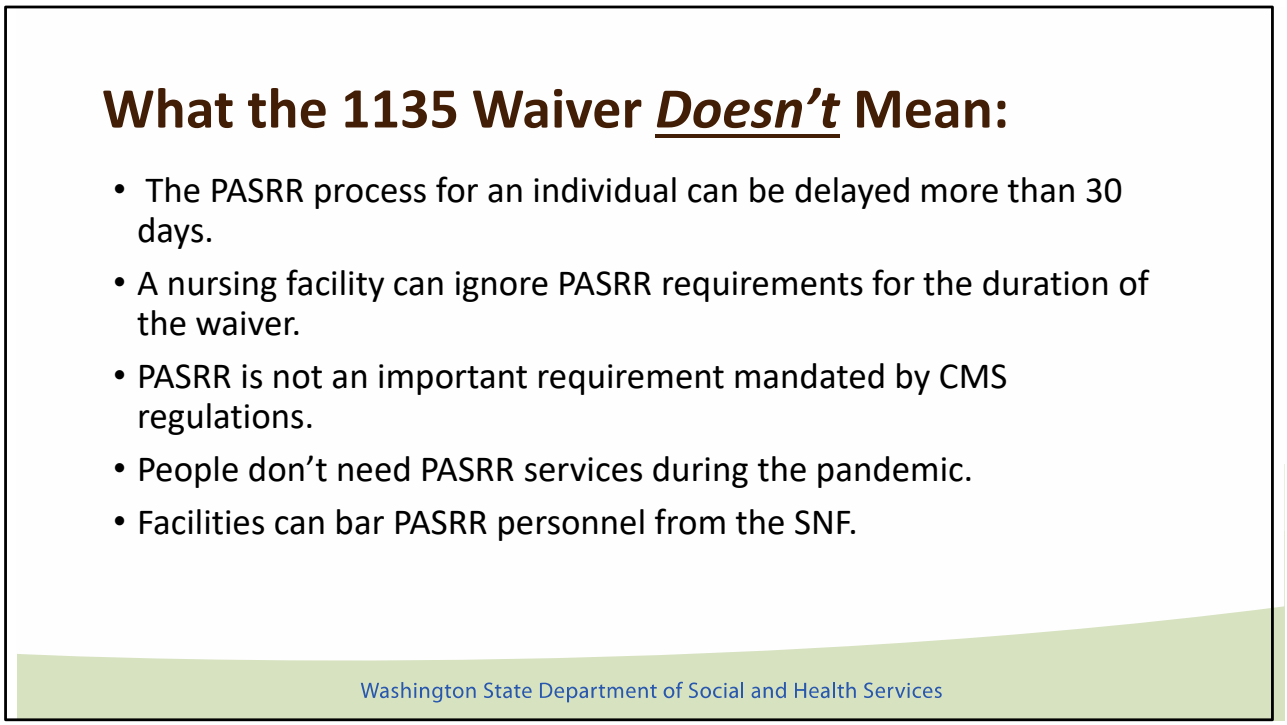
- **The nursing home bears the responsibility to track such admissions and obtain a Level 1 and Level 2 (if indicated) when the 30 days has expired.**

- **A facility could be cited for failing to obtain a PASRR Level 1 and a Level 2 (if indicated) after 30 days of residency.**

- **If the hospital or nursing facility submits a Level 1 prior to or upon admission, PASRR will be responsible for completing the Level 2 as required.**

We strongly encourage facilities to send a Level 1 upon admission if the hospital hasn't

already done so. The PASRR team will complete the process and the facility won't need to track the 30 days.



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What the 1135 Waiver *Doesn't* Mean:

The PASRR process for an individual can be delayed more than 30 days.

- **A nursing facility can ignore PASRR requirements for the duration of the waiver.**
- **PASRR is not an important requirement mandated by CMS regulations.**
- **People don't need PASRR services during the pandemic.**

Some facilities appear to believe that the entire PASRR process has been suspended while the waiver is in effect. This is not true.

Completion of the Level 1 takes only a few minutes, and we highly encourage that facilities submit Level 1s upon admission, if the referring party has not done so already. By doing so, the facility frees itself from the responsibility of tracking the 30-day post-admission timeline.

In fact, completing Level 1s on admission is likely to be much less time-consuming than tracking all admissions to submit Level 1s within 30 days.

How Might COVID-19 Impact Resident Outcomes?

- By postponing the PASRR process, critical services for people with intellectual disabilities or serious mental health conditions are delayed.
- Residents with these conditions may be especially impacted by isolation and need help with coping strategies.
- Staff at many NFs have collaborated with the PASRR team to help support good outcomes for clients.
- PASRR has supplied therapeutic equipment, assistive technology, and remote behavioral health support during this time.

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- By postponing the PASRR process, critical services for people with intellectual disabilities or serious mental health conditions are delayed.
- Residents with these conditions may be especially impacted by isolation and need help with coping strategies.
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- PASRR has supplied therapeutic equipment, assistive technology, and remote behavioral health support during this time.

Here are three examples of collaboration between Nursing Facility staff, DDA PASRR Assessors, and contracted providers:

Client #1: A PASRR Assessor worked with the NF staff regarding someone who is lonely and struggling with understanding why she is no longer able to see her family for visits, whom she missed terribly. The Assessor was able to get a DOH cell phone for the client to be able to speak and FaceTime with her family.

The NF staff spoke to the DDA PASRR Assessor about devices the woman could download books and movies on. DDA PASRR purchased a Kindle. Her family was able to buy her movies and books on tape from Amazon and the NF staff assisted in helping her to be able to use the device.

The same Client had Community Engagement and enjoyed going to the library to check out books and DVDs, although, she was no longer able to physically access the library, due to COVID restrictions. The Community Engagement provider was able to meet with the Client via FaceTime and worked with her to check out free books and movies through the library.

Client #2: Our DDA PASRR Assessor reported to us that the Pandemic is a time of "deepening connections with NF staff, and has been working with a person, their family, and the NF Speech Language Pathologist and the Occupational Therapist to meet the needs of the individual. Speaking with each other they were able to determine that the person is an excellent gamer and has been using the switch for his gaming platform to communicate with family. They are now working on a Bluetooth item that would allow him to connect the switch to his iPad so that he can communicate with greater ease and with what works best for him!

Client #3: A contracted Speech Language Pathologist has been working remotely with a gentleman on his iPad. The SLP reported the Nursing Facility and their activities department have been "awesome" to work with and they are going to start sending data sheets of the resident's progress.

Isolation and Loneliness

- An article in the Journal of the American Medical Directors Association says that an "unfulfilled need for meaningful relationships and losing their self-determination because of institutionalization play crucial roles in feelings of loneliness" among nursing home residents.

- This is true even when people are not seeing the current level of restrictions.

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NF staff have shared our concerns about people's sense of well-being, especially during these times.

According to the Journal of the American Medical Directors Association,

"Preventing loneliness in institutionalized persons is at least as important as helping them with personal hygiene. This is especially important during the COVID-19 pandemic when residents must be protected from contact with other individuals to reduce the risk of infection. Implementation of some of the strategies listed in this article requires education of staff members and supply of required items; however, this effort can significantly improve the quality of life of residents affected by pandemic restrictions."

DDA PASRR can help with necessary equipment for an individual, such as an iPad or other communication devices. DDA PASRR can also provide resources to train activities staff, social workers, therapists, or other NF staff, to help support use of such equipment.

Please encourage your staff to reach out to the DDA PASRR team with any questions.

Other Ways DDA PASRR Can Help People with Intellectual Disabilities or Related Conditions

- Assistive Technology
- Therapeutic Supplies
- Remote Services

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DDA PASRR assessors have purchased assistive technology such as iPads to help nursing facility residents stay in touch with friends and family, they may not be able to meet with in person.

Therapeutic supplies include items recommended by behavior professionals that help with self calming.

Some DDA PASRR services have continued to be provided by phone or teleconference. These include planning for community activities and skill development.

Communication with the PASRR Team is highly important for the resident, the PASRR Team and the nursing facility! Informing the PASRR Team when residents experience changes is HIGHLY important to ensure PASRR is providing the best services possible to the resident. It also helps the nursing facility remain compliant with requirements.

Let PASRR know as soon as possible if a PASRR resident:

Has a significant change in condition.

Is diagnosed with COVID.
Is hospitalized.
Is experiencing behavior challenges.
Is requesting supports in addition to regular NF care.
Passes away.


Residential Care Services (RCS)
Behavioral Health Support Team
RCS has developed the
Behavioral Health Support Team
to provide technical assistance to our facility providers
Washington State Department of Social and Health Services

DH

Behavioral Health Support Team

- **Are you** preparing to **admit a new resident** with a history of challenging behaviors?
- **The Behavioral Health Support Team** offers **Preliminary Technical Assistance (PTA)** for providers who are considering admitting a resident with known challenging behaviors from a medical hospital or another long-term care/community-based placement but are not sure about the admission or would like assistance with preparing for the arrival, BQICs are available to support providers ahead of the admission.
- **These PTAs** involve more extensive research, take a heavy regulatory focus, and involve one or two meetings with the provider.

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Or do you currently have…

- A resident who is difficult to care for due to behaviors?
- Feeling overwhelmed by a resident's behavioral health needs?
- Struggling to create new ways to care for a resident with challenging behaviors?
- Staff who want training about mental health, how to handle behaviors, regulations…or something else?
- Regulatory questions, especially when it comes to caring for residents with challenging behaviors?

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Request a Consultation

- **We have six Behavioral Health Quality Improvement Consultants (BQIC) who can help.**
- **Consultations** are brief, focused work and may include one to two visits with the provider and/or staff.
- **Staffing's** do not rise to the level of requiring a consultation, but the provider may have some questions. For example, how resident rights regulations apply to a particular situation, or questions about their responsibilities regarding a resident who always threatens to discharge from the facility against medical advice.

DH

Behavioral Health Quality Improvement Consultants

- **We also offer:**
  - **Connection Café** are meetings between a BQIC and provider and are less formal than a consultation. The Cafés provide an open forum for staff to ask questions about regulations and other topics that may not be resident specific. Or the meeting may be used to answer general question about many residents in the facility.
  - **Coping with Abuse Training** focuses on helping staff cope with verbal and physical abuse from residents, with the goal of increasing both skill and self-confidence.
    - ✓**"I wish I wasn't such a pushover with her"**
    - ✓**"I can't take being yelled at anymore"**
    - ✓**Am I just supposed to let this resident beat up on me all the time because they have a mental illness.**

DH

Behavioral Health Training Specialist (BHTS)

- **Provide generalized, best practice knowledge on a subject. Not resident specific resident. Trainings are 1-2 hours in length. Continuing Education Credits are available for some.**

- **<u>Here's a menu of trainings that are ready to go.</u>**

- **Co-Occurring Disorders (2 CEUs)**
- **Dementia Training**
- **Person-Centered Care**
- **Hoarding 101**
- **Crisis Response & De-escalation**
- **Trauma Informed Care (1.5 CEUs)**
- **Active Listening**
- **Professional Boundaries**
- **Improving Resident Quality of Life**
- **Documentation Basics**
- **Professional Boundaries: Residents with Sexualized Behavior & Dementia (1 CEU)**

Goals of the BHST and Issues we help with!

Goals

- ✓ Stability for residents with behavioral challenges who are living in a facility setting.
- ✓ Improved quality of care to meet the unique needs of this population.
- ✓ Increased compliance with state and federal regulations by providers who care for residents with behavioral challenges.

Issues we can help with

- ✓ Residents who are aggressive with each other, staff or both.
- ✓ Residents who frequently 'call the state' to make complaints.
- ✓ Staff who are dealing with inappropriate comments from resident, including racist statements.
- ✓ Weak care plan – or really good care plans that aren't implemented consistently.

What Providers are Saying and when to Consider a Referral

What providers are saying

- **"The consultant listened to my concerns and enlightened me with great ideas."**
- **"I felt heard regarding the issues we are facing with the resident."**
- **"I know that support is always there and available, only a phone call away."**

When to consider a referral

- **Facility staff have run out of ideas on how to provide care and services.**
- **The resident is at risk of being discharged due to behaviors.**
- **Staff are concerned about staying in compliance while serving a resident with behavioral health challenges.**
- **There are no (or very limited) mental health supports involved.**

Not Sure if you should refer? That's okay!
We encourage you to reach out and we can figure it out together

- **How to make a referral**
- We just need a little information to get started. Call or email us the following, and a member of our team will be in touch!
  - Referent name and contact information
  - Facility name
  - Resident name and date of birth
  - Brief information about the issue

BHST Email: rcsbhst@dshs.wa.gov
BHST Referral Message Line: 360-725-3445

More information is available at our website and in our brochure

Significant Change of Condition

Significant change definition is in the Resident Assessment Instrument (RAI) Manual, in Chapter 2

Referrals to PASRR for significant change

- Must be done promptly
- Required for individuals who have been previously identified by PASRR as having mental illness (MI), or intellectual disability or related condition (ID/RC)
- Required for those not previously identified.

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What is meant by Significant change:

- A "significant change" is a major decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

A significant change also is:

- Interdisciplinary team determination
- Self limiting – won't normally resolve itself – if not resolved within 2 weeks, sig change assessment should occur. **For PASRR referral, DO NOT wait until the Sig Change Assessment is needed (2 weeks) – make the referral as soon as the changes are evident.**
- Two or more areas of decline or improvement, though staff can decide if one area is significant enough to warrant an assessment

1. Referral required for residents who have been previously identified by PASRR to have mental illness, Intellectual Disability, or a related condition.

2. Referral also required for individuals not previously identified to have MI, ID or related condition, if the individual exhibits behavioral, psychiatric or mood symptoms that suggest MI, or if an ID was not previously identified and evaluated through PASRR
3. Referral required for a resident transferred, admitted or readmitted to a NF following an inpatient psychiatric stay or other equally intensive treatment

A final word about significant change

When making determination, it must be individualized – what is a sig change for one person may not be for another.

Referral to PASRR for significant change may not be necessary if…

- The Resident is expected to return to baseline function within two weeks, and:

- The interdisciplinary team (IDT) can initiate corrective action to address the symptoms, OR
- A short-term illness is causing the symptoms, OR
- Cyclical signs and symptoms are associated with a previous diagnosis.

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When is a Significant Change not necessary?

Example of the IDT initiating corrective action to address symptoms:

- When a resident is experiencing anticipated side effects from a psychoactive medication while the team is attempting to establish an effective dose level
- Corrective action = the IDT can monitor, manage symptoms, and communicate with the physician to make further med adjustments if needed.

Example of short-term illness:

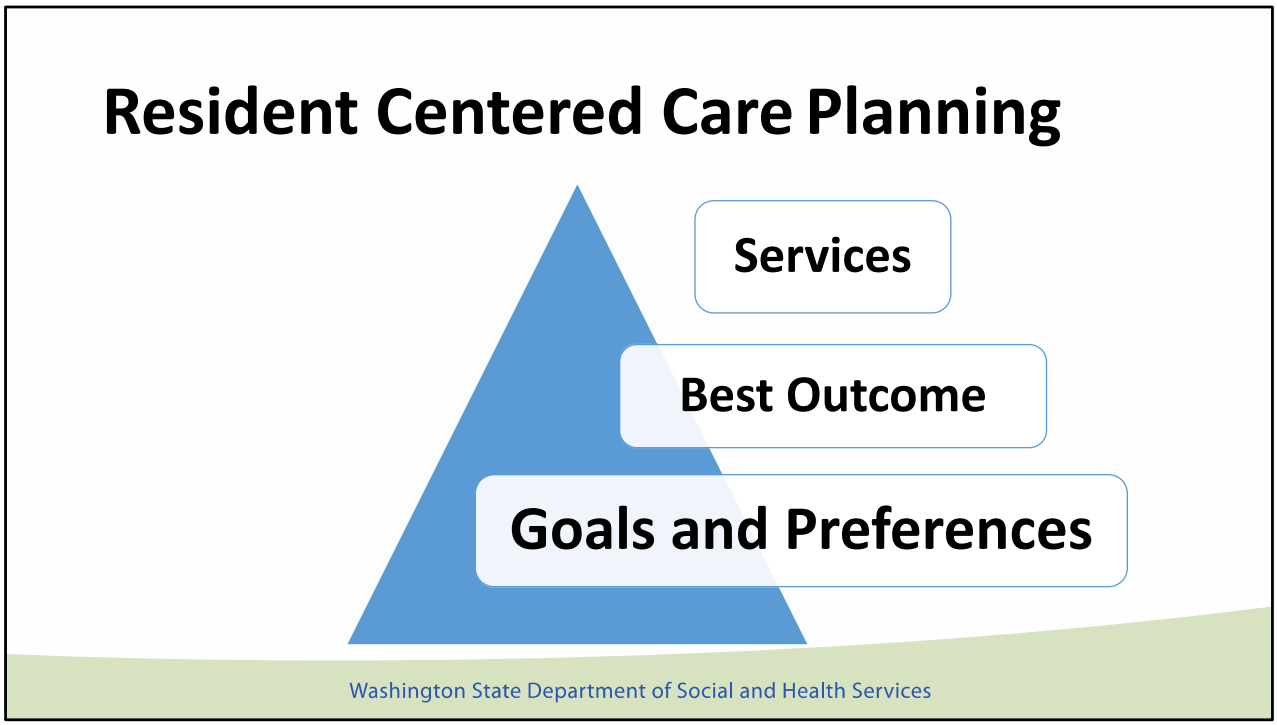
- Resident has a mild fever secondary to a cold, and the IDT expects the resident to fully recover.

Example of cyclical signs and symptoms:

- Resident with previous diagnosis of bi-polar disease shows signs of depressive symptoms.

It is **always** important for the IDT to document team discussion and the team's rationale for determining whether a situation ***is*** a significant change for the resident or not. The team's

thinking should be obvious to someone who was not present at the team's decision-making when documentation is reviewed.



MM:
At the bottom of the pyramid – the foundation, is the resident, and the resident's goals and preferences

Care planning must set objectives for the best outcome for the resident – highest practicable physical, mental and psychosocial wellbeing.
Care planning must determine what interventions or services are needed to achieve the goals of the care plan

Federal and state rules require a care plan based on the assessment. The Care Plan must be:

- Updated as resident needs change, and with a significant change, and reviewed at least quarterly.
- Developed and completed by an interdisciplinary team – IDT's allow different perspectives and expertise while collaborating effectively to create positive outcomes with resident goals.
- Person Centered and individualized.
- The resident or resident representative must be involved in the process of goal

setting and care planning.

How do I incorporate PASRR recommendations from the Level II or follow-up into the care plan?

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MM:
Federal requirements at F656, CMS requires that PASRR recommendations be incorporated into the care plan.

When incorporating the recommendations into the care plan:

First, read the entire Level II report. It contains important information about the individual's history, goals, preferences, strengths, and support needs. It can be a valuable tool to gain knowledge about the resident. Information in the PASRR report can help to strengthen your entire care plan.

For DDA PASRRs, review the "professional evaluations" section. If an evaluation by a professional is requested, the NF must have the evaluation completed and provided to the PASRR assessor within 30 days, along with a copy of the NF care plan. The professional evaluations are important to the assessor because they often help determine what Level 2 services would be most appropriate for the resident.

PASRR recommendations are centered around the needs of each individual and

support the person-centered approach.

Resident Care and PASRR

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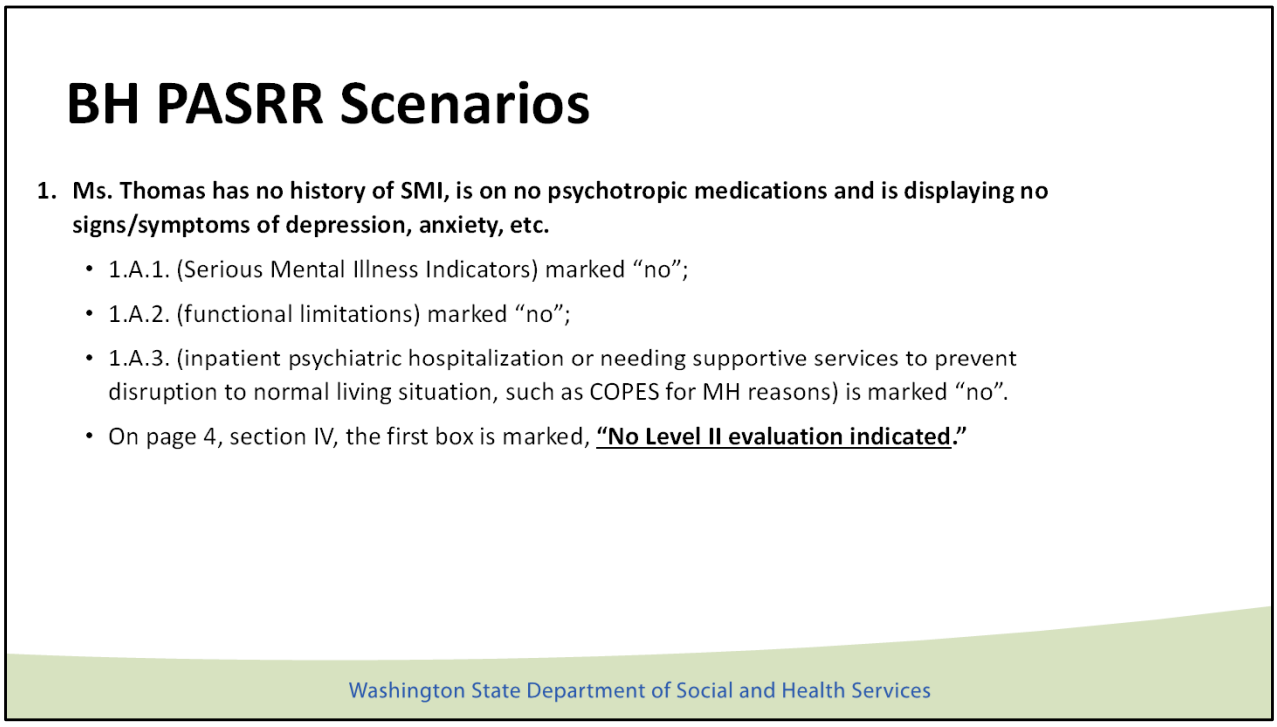
MM:
PASRR helps support better health outcomes and increased satisfaction with care.

- The PASRR evaluation and services are person centered and designed to improve the resident's life. They are individualized to the resident's wishes and needs.
- PASRR services are integrated into the person-centered care plan.
- If communication and coordination is effective, the resident, and facility and PASRR staff are all knowledgeable about the services provided to the resident.

At a minimum, when evaluating the care plan which is at least on a quarterly basis, it would be a good time to review PASRR specialized services and recommendations with the resident/resident representative. If changes are requested or needed sooner, talk with the PASRR Assessor and Evaluators about changes the resident would like to see.



BL

Based on feedback we received from last years webinar, we have included a few common scenarios that a facility may come across while considering the need for a BH PASRR Level I. Please note these following scenario's do not apply to residents that require both ID/RC and Behavioral Health.

1. Ms. Thomas has no history of Serious Mental Illness, she is not on any psychotropic medications, and she is

not displaying any signs or symptoms of depression or anxiety.

2. This instance would be a completely negative Level 1. Please ensure that all 3 sections noted, are marked “NO”
3. Lastly, On page 4, section IV, the first box would be marked, “No Level II evaluation indicated.”

BH PASRR Scenarios

2. **Mr. Smith has a history of depression and has been on Celexa for 6 years, is accepting of his medical hospitalization and the plan for nursing facility placement.**
   - Section 1.A.1. (indicators) will be marked "yes";
   - 1.A.2 (functional limitations) will be marked "no";
   - 1.A.3. will most likely be marked "no."
   - Remember that diagnosis alone will **NOT** make this a positive L1, so page 4, IV, will have the first box marked, **"No Level II evaluation indicated**." Under Additional Comments, please reiterate, "patient with history of depression, currently well-managed on medications."

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BL

In this scenario

1. Mr. Smith has a history of depression, and he has been on Celexa for 6 years.
2. He is accepting of his medical hospitalization and the plan for an upcoming nursing facility placement.
3. This would be an example of a negative level 1. However, please ensure that all 3 sections are marked as indicated.
4. Additionally, page 4, section IV, will have the first box

marked, “No Level II evaluation indicated.”

Under Additional Comments, it would be beneficial to reiterate that the patients symptoms are currently well-managed on his medication.

BH PASRR Scenarios

3. Mr. Brown has a history of depression and is on Celexa and is recuperating from a fall. This medical hospitalization has been rough for him, and he is displaying active symptoms of depression as exhibited by declining/refusing some days of therapies, is irritable with nursing staff, and is withdrawn. However, the medical team think that under normal circumstances, rehab will be <u>less than 30 days</u>.

- Section 1.A.1. (indicators) will be marked "yes";
- 1.A.2. (functional limitations) will now be marked "yes" – since his psychiatric symptoms/behaviors are negatively impacting his care
- The criteria for Section IIA. "Exempted Hospital Discharge" is met and should be notated in as such in Section III.
- Page 4, Section IV, the last box should be marked, "**<u>No Level II evaluation indicated at this time due to categorical determination."</u>**

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BL

In this Scenario,

Mr. Brown has a history of depression, is on Celexa and is currently recuperating from a hip fracture.

1. this medical hospitalization has been rough for him and he is displaying **<u>active symptoms</u>** of depression as exhibited by declining or refusing some days of therapies, He is irritable with nursing staff, and is more withdrawn than he was before.
2. **<u>However</u>**, the medical team think that under normal

circumstances, rehab will be less than 30 days.

3. This would be an example of a negative level 1. However, please ensure that all 3 sections are marked as indicated.
4. Even thought he has **active symptoms** of depression, the medical team thinks his overall stay will be less than 30 days, which is meets the criteria for "Exempted Hospital Discharge"
5. Additionally, Section IV, the 6th box down should be marked, "No Level II evaluation indicated at this time due to exempted hospital discharge".

**Nursing facilities please take note: if rehab does not go as planned and Mr. Brown will stay beyond 30 days, the Level 1 does NOT need to be redone, but the hospital's version needs to be faxed to the PASRR Contractor on day 25.

BH PASRR Scenarios

3. Mr. Clark has a history of depression and has active symptoms of depression. He is deconditioned and will require more than 30 days at the nursing facility.

- Section 1.A.1. (indicators) will be marked "yes";
- 1.A.2. (functional limitations) will be marked "yes";
- 1.A.3. may be either yes or no.
- Skip sections IIA, IIB, and III as these only pertain to <30 days.
- Section IV will be the second box down, "Level II evaluation referral required for SMI."
- **In this circumstance, if the patient is identified while still in the hospital, the patient will need to be seen for the PASRR Level 2 Evaluation preadmission **prior** to admission to the nursing facility. The nursing facility can be cited for accepting a patient with a positive Level I without a completed Level 2.

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BL

In this Scenario, **Mr. Clark has a history of depression and has active symptoms of depression. He is deconditioned and will require more than 30 days at the nursing facility**.

1. This would be an example of a Positive level 1.
2. please ensure that all 3 sections noted below are marked as indicated.
3. Additionally Section IV, the second box down, "Level II evaluation referral required for SMI." Will need to be

selected.

This is a circumstance under which if the patient is identified while still in the hospital, ideally, the patient will need to be seen for the PASRR Level 2 Evaluation, **prior to admission to the nursing facility. The nursing facility can be cited for accepting a patient with a positive L1 without the L2 having been done.

BH PASRR Scenarios

4. Ms. Smith initially had a negative PASRR Level 1 and entered the nursing facility for rehab. Unfortunately, she had some set-backs resulting in a longer than anticipated stay. She became more depressed, withdrawn, and began losing weight. She scored 16/27 on the PHQ-9 and her Primary Physician was contacted regarding the possibility of starting an antidepressant.

- This is an example of a Significant Change.
- Complete a new PASSR Level 1, **noting the significant change date** (approximately) on page 1, and on Page 4.
- Skip sections IIA, IIB and III as these only pertain to <30 days
- Section IV, mark the 5th box down, **"Level II evaluation referral required for significant change."**

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BL

In this scenario **Ms. Smith initially had a negative PASRR Level 1 and entered the nursing facility for rehab. Unfortunately, she had some set-backs resulting in a longer than anticipated stay. She became more depressed, withdrawn, and began losing weight. She scored 16/27 on the PHQ-9 and her Primary Physician was contacted regarding the possibility of starting an antidepressant.**

This is an example of a Significant Change.
In this instance, the facility will complete a new PASSR

Level 1, **noting the significant change date** (approximately) on page 1, and on Page 4.

Additionally Section IV, the 5th box down, **"Level II evaluation referral required for significant change. Will need to be selected.**

Reinvestment Grants

- Washington state participates in the Civil Money Penalty (CMP) Fund Grant Program.
- https://www.dshs.wa.gov/altsa/civil-money-penalty-cmp-funds

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Civil money penalties (CMPs) are fines imposed on nursing facilities that do not meet federal health and safety standards. Washington state receives a portion of the funds collected to be reinvested in support of projects that improve the overall quality of life and/or care of nursing facility residents.

Opportunities are available for nursing homes to participate in grant projects. More information is available at the link in the slide. **Some facilities are using these funds to purchase equipment to assist residents to communicate with others outside of the facility including family and friends. PASRR has found that for residents who are able to communicate with family and friends it has reduced anxiety and increased stability for the resident.**

A Final Thought

PASRR is a partnership between the resident, important people in the resident's life, hospital, NF, and state agencies.

At its center is our common desire to provide person-centered, high-quality services for each individual we serve.

Washington State Department of Social and Health Services

MM:

I want to end with a final thought.

Look at PASRR as a partnership between the resident, important people in the resident's life, hospital, NF, and state agencies.

At its center is our common desire to provide person-centered, high-quality services for each individual we serve.

Where can I find more information?

ID/RC PASRR Internet Site: www.dshs.wa.gov/dda/pasrr

SMI PASRR Internet Site: www.hca.wa.gov/pasrr

Behavioral Health Support for Providers:

www.dshs.wa.gov/altsa/residential-care-services/behavioral-health-support-providers

BHST Email: rcsbhst@dshs.wa.gov

BHST Referral Message Line: 360-725-3445

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DDA—HJ
HCA and DDA maintain PASRR internet sites. At these links, you can find contact information for the PASRR teams, helpful links, FAQs, and –soon- a copy of this presentation. We encourage you to send your staff to these sites, especially when turnover occurs.

Behavioral Health Support for Providers has a website, link to email and a referral line.

PASRR Contacts

- **Developmental Disabilities Administration (ID/RC):** Lonnie Keesee, ID/RC PASRR Unit Manager, lonnie.keesee@dshs.wa.gov; PASRR Program Manager, Heidi Johnston, heidi.johnston@dshs.wa.gov , and Wendy Einer, PASRR Program Coordinator, wendy.einer@dshs.wa.gov.

- **Health Care Authority (SMI):** Beth Loska, PASRR Program Manager elizabeth.loska@hca.wa.gov ; Tabitha Craven, Medical Assistance Program Specialist tabitha.craven@dshs.wa.gov

- **Residential Care Services:** Molly McClintock, NH Policy Program Manager molly.mcclintock@dshs.wa.gov

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The next two slides supply information about how to contact people who work with PASRR in Washington State.

PASRR Contacts

- **RCS Behavioral Health Support Team:** Debbie Hoeman, Behavioral Health Policy Program Manager debbie.hoeman@dshs.wa.gov
- **Home and Community Services:** Julie Cope, System Change Specialist julie.cope@dshs.wa.gov
- **Department of Health:** Liz Gordon, Clinical Care Supervisor, Investigation and Inspection - elizabeth.gordon@DOH.WA.GOV

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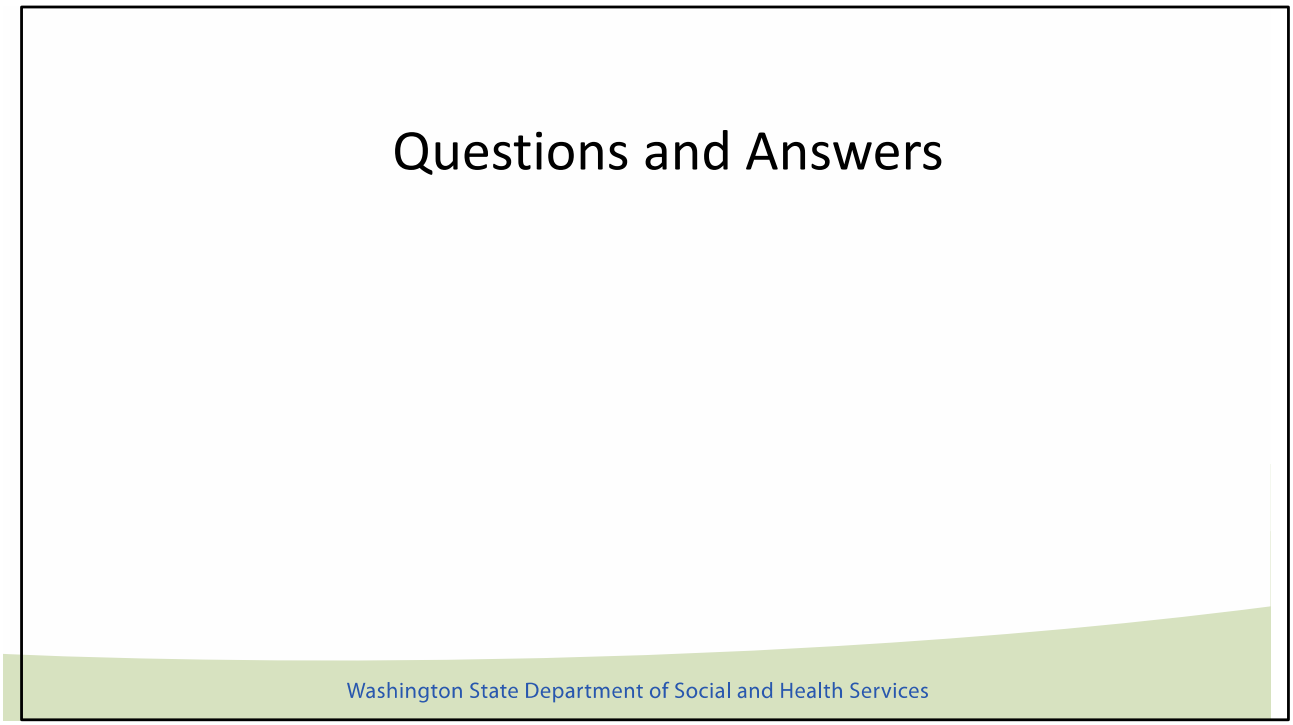

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We would like to thank you for your time today and we are now ready to answer your questions.