

**Mental Health
Preadmission Screening and Resident Review
(PASRR)
LEVEL 2
Training for Mental Health Evaluators**

For more information:

Please visit the DBHR PASRR Information webpage:

www.dshs.wa.gov/pasrr



The following training presentation is on recent revisions to the DBHR Mental Health Preadmission screening and resident review (PASRR) Level 2 forms and process.

For more PASRR related information including all forms and useful links to Federal regulations and technical assistance resources, please copy and save the URL posted on this slide. It will take you to DBHR's PASRR webpage.

Welcome

- Introductions
- A Bit of PASRR Background and Resources
- The DBHR PASRR Process
- Revisions to the DBHR Level 2 PASRR forms – Introduction and Overview
- Distribution of Documentation

Questions? Send them to the PASRR workgroup at:

PASRR_Inquiries@dshs.wa.gov



I would like to express sincere appreciation to the PASRR Level 2 workgroup members who worked so very hard to bring us where we are today, they are:

Vaughn Bonnet PASRR evaluator to Grays Harbor, Jefferson, Lewis and Clallam Counties

Ann Edington PASRR evaluator Providence Behavioral Health Thurston-Mason Counties

Michael Davis – PASRR evaluator Applied Insight, Greater Spokane area and surrounding Counties

Sandra Jones—Quality Assessor for the State’s MH PASRR program, and PASRR Evaluator for King, Whatcom, San Juan Counties

Jennifer Wrye---PASRR evaluator King county

Lori Ledbetter – PASRR evaluator Clark, Cowlitz and Wahkiakum Counties

Maureen Craig – DBHR PASRR Administrative Assistant

We are going to provide you with a little bit of background related to PASRR.

We will briefly go over the DBHR MH PASRR process as it currently exists.

Provide a walkthrough of the revised MH PASRR Level 2 forms (the main purpose of our presentation).

And also go over the distribution of these documents.

I would encourage you to write down any questions , and submit them to the PASRR Question or Comment email on the PASRR webpage. Please note the inbox address listed

on this slide. This is a newly created inbox specifically designated for PASRR related inquiries, and will be routinely monitored. All questions received will be reviewed and answered as quickly as possible.

PASRR - Background

- CFR
- PTAC
- Level 1
- Level 2



PASRR background-

We'll briefly touch on the code of federal regulations (CFR) that drive our decision making and PASRR processes at the state level.

We'll discuss our consultation efforts in working with the federally designated technical assistance center - PTAC

Briefly highlight the Level 1 process and how it contributes to the Level 2

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PASRR – Background Cont.

CFR 42 483.100 – 483.138

<https://www.gpo.gov/>



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The Code of Federal Regulations (CFR) listed on this slide contain the detailed requirements of PASRR.

In brief the CFR Requires:

All patients admitted into a Medicaid certified nursing facility receive a screening for SMI/ID/RC.

PASRR is intended to:

- Identify if an individual may have a SMI/ID or RC.
- That they are placed in the best location that their individual care needs can be met.
- If where they are going to can meet all of their individual care needs or accommodate for any specialized care needs.

The Level 1 screen is the first step in the PASRR process.

The Level 1 must be completed by the referring party prior to admission into a Medicaid certified nursing facility usually a hospital however, it can be completed by a home and community services case worker, or an individual's primary care provider.

If the Level 1 form identifies a potential MI a referral for a more in-depth psychiatric evaluation (the Level 2) is to be made to you the PASRR MH Evaluator and GMHS. This will be the focus of our presentation today the Level 2.

For a complete training presentation previously provided on the PASRR Level 1 screening form, please visit the PASRR webpage listed on the slide at the beginning of this

presentation.

PASRR – Background Cont.

PASRR Technical Assistance Center (PTAC)

- <http://www.pasrrassist.org>



Useful resource of PASRR information-

This site will take you to the PASRR Technical Assistance Center known as PTAC. PTAC is the designated technical assistance center to provide free technical assistance to all states in the improvement of their PASRR processes.

The DBHR MH PASRR Level 2 workgroup has been working in direct consultation with PTAC in:

The review and approval of all our Level 2 documents and instructions.

We have sought guidance on mental health evaluation testing instruments, and common practices,

We also had them review the new substance use disorder questionnaire we developed based on research that we will go over with you later in the presentation.

We also received a training and Q&A session on Dementia and PASRR recommendations.

I would encourage you to visit their website often it contains useful information, webinars, and FAQs, all about PASRR.

I would also encourage you to share their resource with hospital and skilled nursing facility staff during *your* training sessions with them.

It is a valuable, free resource.

PASRR – Background Cont.

The Level 1

- Overview and Training Presentation – Please visit:
<https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/pre-admission-screening-and-resident-review-pasrr>



As I mentioned, this training presentation is about the recent revisions to the DBHR PASRR Level 2 forms and what is expected in their use.

For a complete overview and training presentation of the Level 1 form and further details about PASRR and the Level 1 process, please visit the web link posted on this slide. I again encourage you to share this resource with hospital and nursing facility staff as it is specific to their requirements in the PASRR process. It is also where community providers will be able to find the most current version of the Level 1 form.

As most of you know, the DSHS Level 1 form was revised last summer. The revisions were made out of necessity to better align with CFR requirements. The Level 1 redesign workgroup consisted of staff members from DBHR, DDA, HCS, RCS, HCA and the DOH. PASRR is continuing to evolve and is no longer a static process. Change is difficult, but at times, necessary. Ultimately, meeting the behavioral health needs of individuals admitted into a Medicaid certified nursing facility is our primary purpose.

I mention the Level 1 form because as you know, the Level 2 PASRR process begins after the Level 1 referral is received.

Once referral for a level 2 is made from a hospital or community provider to a SNF, PASRR contractors have **72 hours** to complete the Level 2. Level 2's are to be completed **PRIOR** to admission into a SNF hence the "Preadmission" in PASRR. If the individual already resides in the SNF the Level 2 must be completed within 14 days from the day that referral was made. This is usually in the case of a significant change in condition, or upon expiration of

an exempted hospital discharge.

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PASRR – Background Cont.

How we got here

- Why revise?
- Level 2 Workgroup



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Why Revise-

As you know, our previous Level 2 forms required to list multiaxial diagnosis which the DSM 5 has since removed.

And with the implementation of ICD 10 and DSM 5 it became necessary to revise our Level 2 form.

Level 2 Workgroup formation:

Volunteers consisting of PASRR GMHS' were asked to participate in the revision of the DBHR MH Level 2 forms.

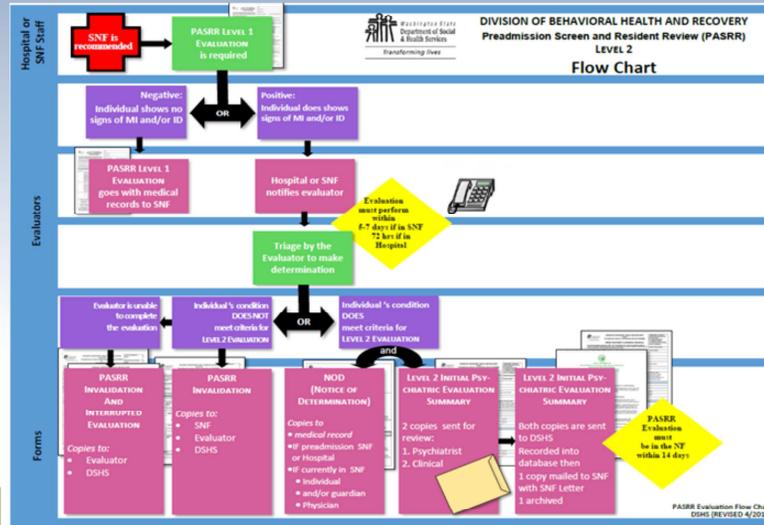
The workgroup meets on a monthly basis and has participants from throughout the state. The result of the dedication and talent of the individuals who participated on the workgroup along with review and input from our contracted psychiatrists is what we will be sharing with you.

The workgroup reviewed each separate Level 2 form line-by-line word-by-word. Cross walked CFR requirements, and sent all final versions to our 2 contracted psychiatrists and PTAC for review and input.

The workgroup then reviewed all of their input and incorporated recommendations into the forms after review and discussion.

PASRR – The Process

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PASRR Evaluation Flow

PASRR – Level 2 Forms

The Revisions

- Initial Psychiatric Evaluation
- Notice of Determination (NOD)
- Invalidation
- Follow-up/Significant Change
- Interrupted



As a PASRR evaluator you are familiar with our forms and are aware that there are varying degrees or “intensity” if you will, of the PASRR Level 2 Evaluation:

- The Initial Psychiatric Evaluation – A Comprehensive Psychiatric Evaluation that will contain behavioral health service recommendations for the person with an identified SMI. (Completed *prior* to admission into a SNF. Usually while at a hospital or by a community physician, HCS or some other community referring agency.
- The Notice of Determination-The notification of the determination for SNF services and any identified SMI or need for specialized behavioral health services is to be provided to the appropriate individuals listed on the form.
- The Invalidation – One could consider this “triage.” An Invalidation consists of a brief interview of staff or the individual that may include an analysis of data and behaviors to invalidate the presence of an SMI, and that include facts that support the referred individual of NOT having a SMI DX nor would require, or benefit from any specialized behavioral health services.
- The Follow-up or Significant Change in Condition – Referral for a change in the individual’s previous behavioral health status that requires another full Level 2 Psychiatric Evaluation and any changes to their behavioral health recommendations that will require an update to their plan of care.

- The Interrupted Evaluation- The initial face to face interview has begun toward the completion of a full psychiatric evaluation. This form is used when the evaluation is halted due to obvious findings that the individual does not have a SMI. This usually lasts no longer than a period of (1 up to 4) 15 minute time segments.

PASRR – Level 2 Forms

THE INITIAL PSYCHIATRIC EVALUATION



The first form in our PASRR process we will discuss is the PASRR Initial Psychiatric Evaluation Summary. It follows the request for a referral from a positive Level 1 Screen. This form is to be completed within 72 hours if the individual is currently in a hospital being referred to a Medicaid certified nursing facility or if the individual is currently residing in a SNF, it is to be completed within 14 days from the referral.

This form completes the Level 2 process for potentially mentally ill persons in a Medicaid certified nursing facility. Based on the diagnosis and need for treatment, a determination will be made regarding the most appropriate placement and plan of care.

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PASRR – Level 2 Forms
Initial Psychiatric Evaluation

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**DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
Level 2
Preadmission Screen and Resident Review (PASRR)
Initial Psychiatric Evaluation Summary**

The following evaluation is required by OBRA 1987 to complete the Level 2 process for potentially mentally ill persons in a Medicaid certified nursing facility. Based on the diagnosis and need for treatment, a determination will be made regarding the most appropriate placement and plan of care.

NAME: LAST			FIRST	MIDDLE	ASSESSMENT CATEGORY (CHECK APPROPRIATE BOX) <input type="checkbox"/> Preadmission <input type="checkbox"/> Initial Nursing Facility <input type="checkbox"/> Significant Change <input type="checkbox"/> Medicaid Covered Individual
NURSING FACILITY PLACEMENT AND MAILING ADDRESS					DATE OF REFERRAL
REASON FOR REFERRAL: CURRENT SYMPTOMS AND BEHAVIORS					DATE OF EVALUATION
PASRR Rights reviewed with individual: <input type="checkbox"/> Yes <input type="checkbox"/> No Individual agreed to evaluation: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:					DATE OF BIRTH
SITE OF EVALUATION: <input type="checkbox"/> Home <input type="checkbox"/> Nursing facility <input type="checkbox"/> Community facility <input type="checkbox"/> Psychiatric inpatient setting <input type="checkbox"/> General medical hospital setting <input type="checkbox"/> Other (specify):					
NAME OF SITE OF EVALUATION:					
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female		PRIMARY LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Other (specify):			
RACE / ETHNICITY <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> White, not of Hispanic origin		MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Unknown		PRIMARY LIVING SITUATION DURING THE PAST YEAR <input type="checkbox"/> Home <input type="checkbox"/> Nursing facility <input type="checkbox"/> Homeless <input type="checkbox"/> State Hospital <input type="checkbox"/> Other (specify):	
				<input type="checkbox"/> Other psychiatric inpatient <input type="checkbox"/> Mental Health residential <input type="checkbox"/> Developmental Disability facility <input type="checkbox"/> Other residential program	

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ASSESSMENT CATEGORY BOX

One box **must** be marked; Preadmission, Initial Nursing Facility, or Significant Change in Condition.

If individual is covered by Medicaid, check the box.

DATE BOXES

Date of Referral - Type in the date the referral was made.

Date of Evaluation - Type in the date the evaluation was completed or attempted.

Date of Birth - Type in the date of birth of the individual.

NAME

Type in the last name of the individual - check correct spelling.

Type in the first name of the individual - check correct spelling.

Type in the middle name/initial of the individual - check correct spelling.

If the individual does not have a middle name, leave it blank.

NURSING FACILITY PLACEMENT AND MAILING ADDRESS

Type in the name and address of skilled nursing facility where the individual is going to be placed.

Make every effort to identify the facility of discharge. If unknown, continue to follow up with

referring party to find out placement and notify DBHR.

REASON FOR REFERRAL

List all current symptoms and behaviors that lead to the referral.

PASRR RIGHTS

Review PASRR rights with the individual and check the box.

Did the individual agree to the PASRR evaluation - Check the appropriate box. If no, indicate reasons why in the comment box.

SITE OF EVALUATION

Check appropriate box indicating the location of where the evaluation was completed. If other, write in location site.

NAME OF SITE OF EVALUATION

Type in name of location where evaluation was conducted.

GENDER

Check appropriate box - what gender the individual self identifies as.

PRIMARY LANGUAGE

Check appropriate box. Specify other primary language.

RACE/ETHNICITY

Check appropriate box.

MARITAL STATUS

Check appropriate box.

PRIMARY LIVING SITUATION DURING THE PAST YEAR

Check the appropriate box. If other, specify other living situation.

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

1. Diagnosis Indicated by Present Evaluation	
DSM:	
Medical:	
Psychiatric Diagnoses of record:	
PRINT NAME OF PERSON COMPLETING EVALUATION:	TITLE:
SIGNATURE OF PERSON COMPLETING EVALUATION:	DATE:
CONTRACTOR:	



Section 1.

DSM:

List all diagnoses indicated by the present evaluation using the most current DSM (you **MUST** include the **CORRECT** DSM 5 code)

Medical:

List all applicable medical diagnoses.

Psych:

List all psychiatric diagnoses of record.

PRINT NAME and TITLE

SIGNATURE - Sign and type in the date form was completed.

CONTRACTOR - If you are working for a contractor, type in the name of the contractor.

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PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

Comments / Recommendations of the Reviewing Psychiatrist	
SIGNATURE OF REVIEWING PSYCHIATRIST	DATE:
DEPARTMENT OF SOCIAL AND HEALTH SERVICES – DBHR DESIGNEE'S SIGNATURE	DATE:

LEVEL 2 PASRR INITIAL PSYCHIATRIC EVALUATION
DSHS 14-338 (REVISED – 02/2016)

Page 1 of 3



PO Box 45050, Olympia, WA 98504 | www.dshs.wa.gov 13

Comments/Recommendations of the Reviewing Psychiatrist:

The psychiatrist will write all recommendations or comments related to the completed evaluation here.

This section is to be completed only by the reviewing psychiatrist.

This is the portion to be reviewed by the SNF staff for implementation of any identified specialized behavioral health services for incorporation into the individual’s plan of care.

SIGNATURE

Sign and write in the date upon completion of psychiatric review.

Department of Social and Health Services/DBHR Designee

Sign and date upon completion.

Washington State Department of Social and Health Services

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PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

2. Recommendations for Plan of Care

Follow-up Evaluation Date:
 No follow-up Evaluation Needed (Unless significant change in condition occurs while in nursing facility)

A. Mental Health Services: provide explanation for recommended service(s):

1. Acute psychiatric hospitalization (The mental health needs of the individual cannot be met at the skilled nursing facility):

2. Specialized services can be provided in a skilled nursing facility by a licensed mental health professional or mental health agency for:

a. Individual Services, i.e., case management, therapy, case consultation for:

b. Psychiatric assessment and medication evaluation / management for:

3. No mental health services are recommended at this time (explain below):

B. Recommendations for Nursing Facility: (include likes and dislikes about people, and community environments, what helps keep them calm):

1. Environmental

2. Staff approaches / training:

3. Behavioral supports:

4. Activities:

5. Other:

C. Other Medical Services:

1. Psychiatric medication management as currently provided by the individual's primary physician (non-psychiatrist).

2. Medical assessment to address the following physical health symptoms:

3. Ancillary services (podiatry, PT, dental, etc.):

D. Recommendations for Community Transition:

1. Is it possible for this individual to reside in the community and have their needs met?

2. Individual's stated preference of living situation in community:

3. Evaluator recommendations for community transition:

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Section 2. Recommendations for Plan of Care

Follow up evaluation date

Check the appropriate box. If a follow up evaluation is needed, indicate a **date** to follow up.

A. MENTAL HEALTH SERVICES - Check the appropriate box. Provide a specific explanation.

1. **Acute psychiatric hospitalization** - if checked, the MH needs of the individual cannot be met at the SNF. Notify staff as appropriate.
2. **Specialized services** - check the appropriate box - (a and/or b) and provide specific examples.
3. **No mental health services** are needed - Explain why.

B. RECOMMENDATIONS FOR NURSING FACILITY -

This section is to provide the nursing facility staff with information to help them meet the mental health needs of the individual while they are in the nursing facility.

Check applicable boxes (1-5).

Write your recommendations in a manner that is appropriate for all levels of nursing facility staff. **Be**

descriptive. Ask “**person centered**” questions that include likes and dislikes about people, and

community environments, and what helps to keep them calm. Recommendations **must** be specific to the individual.

C. OTHER MEDICAL SERVICES - Check appropriate boxes (1-4).

2. Note any physical health symptoms that may impact their psychiatric condition.
3. Note any ancillary services that will benefit the individual during their nursing facility stay.
4. Note any substance use treatment (tobacco, alcohol, or other).

D. RECOMENDATIONS FOR COMMUNITY TRANSITION -

1. Note if the individual's current needs could be met in the community.
2. Note individual's stated preference of living situation in community.
3. Note specific recommendations that will help to facilitate a potentially successful transition into the community.

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

3. Presenting Problem(s)
A. Current psychiatric problems and status:
B. Recent relevant events (list reason(s) for hospitalization and/or SNF placement / referral):
C. Behavioral and emotional problems:
D. Interview and Impressions:



Section 3. Presenting Problems:

- List current symptoms and behaviors as exhibited during interview, conversations with staff and medical record information as noted in the chart.
- List reasons for hospitalization and/or nursing facility placement.
- List behaviors and emotional problems exhibited during the interview and self-reported by the individual and/or as reported by staff.

This is where information you observed and gathered during the interview is written and interpreted. Write your conclusions in a manner that is appropriate for all levels of nursing facility staff. Note any discrepancies between what is documented as opposed to what is observed.

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

4. Psychiatric History	
A. Psychiatric history (include history of suicide attempts and risk of harm to self or others):	
B. Date of onset of psychiatric symptoms: <input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 – 5 years <input type="checkbox"/> More than 5 years <input type="checkbox"/> Unknown	
C. Psychiatric hospitalizations:	
Within past two years:	Total during lifetime:
<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> 1 – 5 hospitalizations	<input type="checkbox"/> 1 – 5 hospitalizations
<input type="checkbox"/> More than 5 hospitalizations	<input type="checkbox"/> More than 5 hospitalizations
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
D. Provide information of psychiatric hospitalizations (reason, location, dates, course of treatment) with emphasis on most recent hospitalization:	
E. History of previous medications with response/lack of response (if known):	
F. Current mental health services provider / Behavioral Health Organization (BHO) / agency name and telephone number:	
NAME: LAST	FIRST
DATE OF BIRTH	
LEVEL 2 PASRR INITIAL PSYCHIATRIC EVALUATION	
DSHS 14-338 (REVISED – 02/2016)	
Page 2 of 3	



Section 4. Psychiatric History

- List all psychiatric history. Include inpatient treatment, outpatient treatment, any suicide attempts, or risk of harm to self or others.
- Onset of Psychiatric Symptoms - Check appropriate box
- Psychiatric Hospitalizations - Check appropriate boxes
- List reasons and course of treatment during psychiatric hospitalization(s) with emphasis on most recent.
- History of previous medications-List any known history or adverse reactions or failed trials to any psychiatric medications.
- Current MH services - List current mental health provider and frequency of services if known and Behavioral Health Organization.

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

6. Substance Use History	
A. Is there history or current use of alcohol or substances for this individual?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
B. If yes, specify substance(s) used, dates, circumstances (current and past) and treatments received (location and date(s) of treatment):	
C. Substance use disorder questionnaire attached:	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:



Section 5. Substance Use History:

- Is there a history or current use of substance or alcohol for this individual? Check appropriate box.
- If yes, specify substances, dates and circumstances on form.
- If yes, complete substance use disorder questionnaire and attach it with the evaluation.

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PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

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DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
Level 2
Preadmission Screen and Resident Review (PASRR)
Supplemental Substance Use Questionnaire

DATE OF EVALUATION: _____
DATE OF BIRTH: _____

NAME: LAST: _____ FIRST: _____ MIDDLE: _____

NURSING FACILITY PLACEMENT: _____

NURSING FACILITY MAILING ADDRESS: _____

1. Current Substance Use

A. Do you currently use drugs or alcohol? Yes No
If yes, how often? _____
Specify substance and amount: _____

B. Feel that your drug or alcohol use caused problems in your social, family, financial, or work life? Yes No
If yes, describe: _____

C. Feel that you need or would benefit from drug or alcohol treatment? Yes No

D. Do you have a history of tobacco product (including vaporizer) use? Yes No
If yes, how much? _____
Method of use: _____
(Circle date if no longer using)

E. Do you have a family history of substance or alcohol abuse? Yes No
If yes, describe type and relationship: _____

2. Past Substance Use

A. In the past, did you use alcohol or drugs? Yes No
Specify substance and amount: _____
If yes, how often? _____

B. Feel that your drug or alcohol use caused problems in your social, family, financial, or work life? Yes No
If yes, describe: _____

C. Did you seek help for drug or alcohol use? Yes No
If yes, list from who, or what groups, and when? _____

Evaluator Information

SIGNATURE: _____ DATE: _____
PRINT NAME: _____ TITLE: _____
CONTRACTOR: _____ COUNTY: _____

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Substance Use Disorder Questionnaire:

This slide shows the new substance use disorder questionnaire that is to be submitted along with the completed Level 2 evaluation if the individual shows evidence of a possible substance use disorder.

It is basically self-explanatory by asking the individual the questions listed on the form and writing down answers provided.

The intent of this SUD questionnaire is to help the SNF seek out a SUD assessment by a CDP if needed.

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

6. Family History
A. Family history of mental illness? (note relationship):
B. Family history of suicide? (note relationship):
C. Family history of alcohol/substance abuse? (note relationship):



Section 6 Family History

Is there a family history of mental illness for the individual? If yes, note relationship.
Is there a family history of suicide for the individual? If yes, note relationship.
Is there a family history of substance use for the individual? If yes, note relationship.

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

7. Current Medical Information and Medications

- A. Attach copies of laboratory reports, consultations, recent medical notes and the comprehensive history and physical examination and medical diagnoses list for psychiatric review.
- *Required contents as necessary to determine diagnoses:** complete medical history; review of all systems; specific evaluation of the individual's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; and in case of abnormal finding(s), which are the basis for a NF placement, additional evaluation conducted by appropriate specialists.
- B. Attach copies of medication use profile: for purposes of psychiatric review, record medication, copy of the current physicians orders. Specify additions / changes for all medications, including frequency of PRN medications, during the past 90 days.
- C. List current psychotropic medications:



Section 7. Current Medical Information and Medications:

A. Attach copies of all supporting medical documentation as listed on the form.

This documentation must accompany the evaluation for psychiatric review.

B. Attach copies of medication use profile as listed on the form. Attach a copy of the current physician orders. Specify additions or changes for all medications, including frequency of PRN medications, during the past 90 days. **This documentation must accompany the evaluation for psychiatric review.**

C. List all psychotropic medications. **This documentation must accompany the evaluation for psychiatric review.**

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

8. Psychological Test Instruments		
Total Score:	Instruments:	Comments:
	Mini Mental Status Exam (MMSE)	
	Geriatric Depression Scale (GDS)	
	Brief Psychiatric Rating Scale (BPRS)	
	Mood Disorder Questionnaire (MDQ)	
Functional assessment: (include review of MDS, any OT, PT, Speech Therapy documentation) See attachments for complete information.		



Section 8 Psychological Test Instruments-

Testing Instruments

Complete all appropriate tests as needed documenting score and particular findings in the comment section. If the test is not performed or does not apply, write N/A in score box for each test.

Functional assessment

Include a review of the MDS, or any OT, PT, and Speech Therapy consults. This documentation **must** accompany the evaluation.

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

9. Behavioral Health Services	
A. Has the individual requested behavioral health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type? Comment:
B. Agrees to recommended behavioral health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain Comment:
C. Does the individual perceive a need for mental health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No Comment:



Section 9. Behavioral Health Services

Indicate if the individual has requested behavioral health services.

Indicate if the individual agrees to any recommended behavioral health services or if they are uncertain.

Indicate if the individual perceives a need for behavioral health services.

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

10. Additional Information		
A. Strengths and assets: (according to evaluation findings)		
B. Individual's stated goals:		
C. Identify current support network and adult family situation (include names, relationship, potential support provided):		
D. Individual's identified skills, strengths and favorite activities with interests:		
NAME: LAST	FIRST	DATE OF BIRTH

LEVEL 2 INITIAL PSYCHIATRIC EVALUATION
DSHS 14-338 (REVISED – 02/2016)

Page 3 of 3



Section 10.

List the individual's strengths and assets.

List the individual's goals.

Identify and list the individual's current support network and adult family situation – List names, relationship, any potential support provided.

List the individual's identified skills, strengths and favorite activities with interests.

PASRR – Level 2 Forms
Initial Psychiatric Evaluation-Cont.

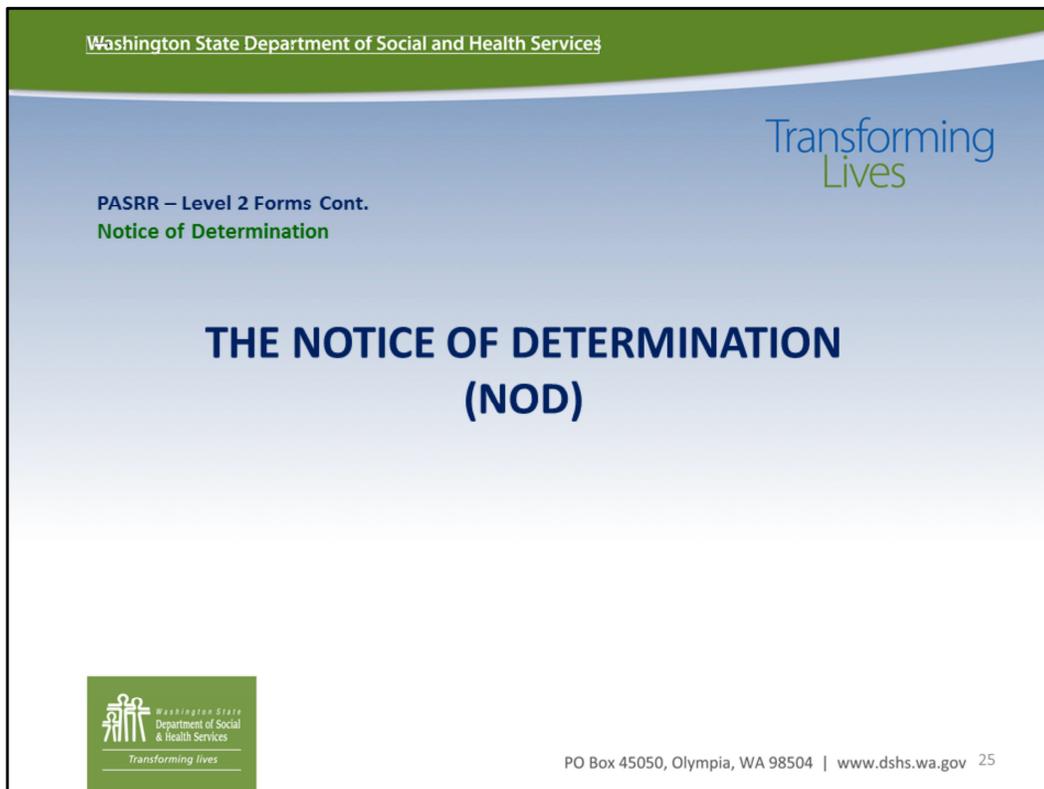
DISTRIBUTION OF THIS DOCUMENT

- Immediately send two (2) copies and any pertinent medical documentation to the Psychiatrist for psychiatric, quality assessor review, and for DBHR processing.
- Complete the Notice of Determination



Upon completion of Level 2 psychiatric evaluations, immediately send two (2) copies and any pertinent medical documentation to the Psychiatrist for psychiatric, quality assessor review, and for DBHR processing.

Complete the NOD and distribute as instructed.



The Notice of Determination

Use this form upon completion of a PASRR Level 2 Initial Psychiatric Evaluation Summary.

The purpose of this form:

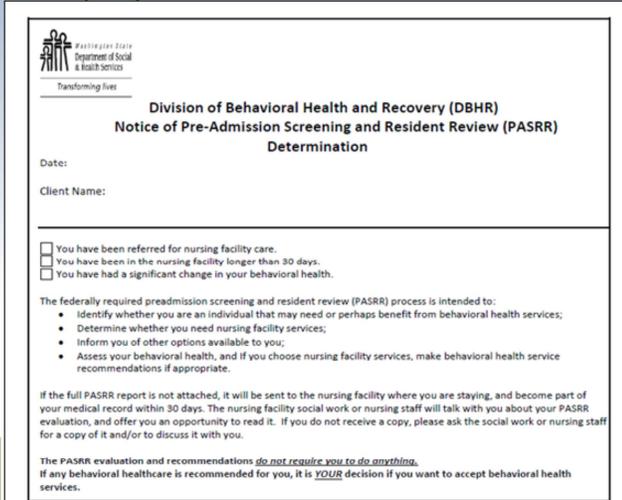
To fulfill 42 CFR 483.128 distribution and determination notification requirements when a PASRR Level 2 evaluation has been performed and why.

To provide written notification of the determination(s) made to the client and/or family member and SNF for inclusion into the medical record.

To provide notification to the SNF that a written report is in process and is forthcoming.

To provide notification to the client of community living options, their appeal rights, and instructions on how request a fair hearing

PASRR – Level 2 Forms Cont.
Notice of Determination (NOD)



The form is titled "Division of Behavioral Health and Recovery (DBHR) Notice of Pre-Admission Screening and Resident Review (PASRR) Determination". It includes a header with the Washington State Department of Social & Health Services logo and the slogan "Transforming lives". Below the header, there are fields for "Date:" and "Client Name:". A section with three checkboxes asks if the client has been referred for nursing facility care, been in a nursing facility longer than 30 days, or had a significant change in behavioral health. A paragraph explains the purpose of the PASRR process: to identify if an individual needs behavioral health services, inform of other options, and assess behavioral health. A note states that the full PASRR report will be sent to the nursing facility within 30 days. A final note clarifies that PASRR recommendations do not require the client to do anything, and it is their decision to accept behavioral health services.



1. Write in the Date
2. Write in Client Name
3. Check the appropriate box (referred for NF care etc.)

PASRR – Level 2 Forms
Notice of Determination (NOD) –Cont.

Determinations

Based on a review of your records and conversations with you and others involved in your care, DBHR has made the following determinations, effective as of the date of this notice.

DBHR has determined that:

- You do do not have a mental health diagnosis, as defined in federal regulations (42 C.F.R. §483.102(1).
- You do do not meet the requirements for nursing facility level of care, as defined in WAC 388-106-0355.
- If you have a mental health diagnosis and you meet the requirements for nursing facility level of care, you do do not currently require specialized behavioral health services.
If you are determined to need these services, they would help you to acquire skills or behaviors that will enable you to function with as much self determination and independence as possible, and/or in order to prevent or slow the loss of your current functional status, while you reside at a nursing facility.

Page 1 of 4



4. Discuss with the client if able (or POA etc.) the intent of the PASRR see bullets on form
5. ***IMPORTANT* Please discuss with the client that any recommendations from the evaluation do not require them to do anything.** And that if any behavioral healthcare is recommended, it is THEIR decision if they want to accept behavioral health services.
6. Check each appropriate box under (DBHR has determined) section:

PASRR – Level 2 Forms
Notice of Determination (NOD) –Cont.

- If you have **NOT** been determined to require specialized behavioral health services, that determination is based on the following reason(s):
 - You have a serious physical illness which results in a level of impairment so severe that you are not expected to benefit from specialized behavioral health services.
 - You have a diagnosis of dementia which results in a level of impairment so severe that you are not expected to benefit from specialized behavioral health services.
 - You are experiencing a delirium that prevents an accurate mental health diagnosis.
 - DBHR has not identified any services in addition to services provided by the nursing facility that will assist you to function with as much independence as possible, and/or prevent or slow any loss of your functional ability.

Legal Guardian Name:	
Address Line 1:	
Address Line 2:	
City, State, Zip:	

Evaluator Signature:	
Evaluator Printed Name	
Evaluator Title:	
Organization:	
Evaluator Phone:	



6. Check each appropriate box under (DBHR has determined) section:

7. Fill in guardian name etc.

8. Fill in your name etc.

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**PASRR – Level 2 Forms
Notice of Determination (NOD) –Cont.**

<p>Distribution of this Notice:</p> <p>Pre-Admission to Nursing Facility:</p> <ul style="list-style-type: none"> • Copy to Hospital • Copy to Skilled Nursing Facility • Copy to Patient and/or legal guardian <p>Nursing Facility:</p> <ul style="list-style-type: none"> • Copy to patient record • Copy to attending physician <p>Distribution Comments:</p>
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Page 2 of 4

Washington State Department of Social & Health Services
Transforming lives

PO Box 45050, Olympia, WA 98504 | www.dshs.wa.gov 29

Please provide a copy of this notice to:

The client (If appropriate and client is willing to accept it)

The referring facility/entity e.g. hospital social worker (to be included it in the admission packet for the SNF).

Use the distribution comments section for any additional information that will be helpful to know

e.g. copy to pt. declined because they didn't have their purse with them etc. etc.

Gave instructions to hospital social worker to include in dc packet to SNF

PASRR – Level 2 Forms
Notice of Determination (NOD) –Cont.

This determination is being made by the following authority:
Washington Administrative Code (WAC) 182-200-0105 Am I eligible for nursing facility care services? WAC 182-97-1920 Preadmission screening—Level I. WAC 182-97-2000 Preadmission screening and resident review (PASRR) determination and appeal rights. WAC 182-97-1940 Advanced categorical determinations, not subject to preadmission screening—Level II. WAC 182-97-1960 Preadmission screening—Level II.
Your Appeal Rights
You have ninety (90) days from the receipt of this notice to appeal any of the following decisions: <ul style="list-style-type: none">• That you do not meet the requirements for nursing facility level of care; or• That you are not in need of specialized behavioral health services. You have the following rights: <ul style="list-style-type: none">• To decline or terminate services at any time.• To have another person represent you at the hearing (DHS does not pay for attorneys, but free or low cost legal assistance may be available in your community. For additional information call 1-888-201-1014).• To receive copies of your PASRR evaluation, determination and any recommendations.• To submit documents into evidence.• To testify at the hearing and to present witnesses to testify on your behalf, and• To cross examine witnesses testifying for the department. A form to request an administrative (fair) hearing is included.
Optional Community Residential Settings
Other residential programs and services that may be available to you: Adult Family Homes Adult Family Homes are regular neighborhood homes where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision and varying levels of assistance with care are provided. Some provide occasional nursing care. Some offer specialized care for people with mental health issues, developmental disabilities or dementia. The home can have two to six residents and is licensed by the state. Assisted Living Facilities A long term care option that provides personal care support services such as meals, medication management, bathing, dressing, and transportation. Supported Living Services Supported living services provide support in activities of daily living to persons who live in their own homes or congregate care facilities in the community. Supports may vary from a few hours per month up to 24 hours per day of one-to-one support. Clients pay for their own rent, food, and other personal expenses.



The information above is required to have in the NOD
Reference of authority – WAC etc.
Appeal rights for the individual are now listed along with options of other types of community residential settings

PASRR – Level 2 Forms
Notice of Determination (NOD) –Cont.

This determination is being made by the following authority:

Washington Administrative Code (WAC) 358-100-0105
Am I eligible for nursing facility care services?
WAC 358-97-1920
Preadmission screening—Level I.
WAC 358-97-2000
Preadmission screening and resident review (PASRR) determination and appeal rights.
WAC 358-97-1940
Advanced categorical determinations, not subject to preadmission screening—Level II.
WAC 358-97-1960
Preadmission screening—Level II.

Your Appeal Rights

You have ninety (90) days from the receipt of this notice to appeal any of the following decisions:

- That you do not meet the requirements for nursing facility level of care; or
- That you are not in need of specialized behavioral health services.

You have the following rights:

- To decline or terminate services at any time.
- To have another person represent you at the hearing (DSHS does not pay for attorneys, but free or low cost legal assistance may be available in your community. For additional information call 1-888-201-1014).
- To receive copies of your PASRR evaluation, determination and any recommendations.
- To submit documents into evidence.
- To testify at the hearing and to present witnesses to testify on your behalf, and
- To cross examine witnesses testifying for the department.

A form to request an administrative (fair) hearing is included.

Optional Community Residential Settings

Other residential programs and services that may be available to you:

Adult Family Homes
Adult Family Homes are regular neighborhood homes where staff assumes responsibility for the safety and well-being of the adult. A room, meals, laundry, supervision and varying levels of assistance with care are provided. Some provide occasional nursing care. Some offer specialized care for people with mental health issues, developmental disabilities or dementia. The home can have two to six residents and is licensed by the state.

Assisted Living Facilities
A long term care option that provides personal care support services such as meals, medication management, bathing, dressing, and transportation.

Supported Living Services
Supported Living services provide support in activities of daily living to persons who live in their own homes or congregate care facilities in the community. Supports may vary from a few hours per month up to 24 hours per day of one-to-one support. Clients pay for their own rent, food, and other personal expenses.

Page 1 of 4



The request for hearing form is also now a part of the NOD. The individual must be provided with the means to appeal the determination and instructions how to do so by requesting a fair hearing.

PASRR – Level 2 Forms
Notice of Determination (NOD) –Cont.

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Washington State
Department of Social
& Health Services
Transforming Lives

**DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
REQUEST FOR MENTAL HEALTH
FAIR HEARING**

Per Chapter 182-526 for DSHS hearing rules

MAIL YOUR REQUEST TO THIS ADDRESS: OFFICE OF ADMINISTRATIVE HEARINGS (OAH) PO Box 42488 Olympia, WA 98504-2489 Phone: (360) 407-2700 Fax: (360) 664-8721	FOR AGENCY USE ONLY Verbal request taken: _____ Date: _____ Name: _____ Telephone Number: _____
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I am requesting a hearing because of the following PASRR determination(s) made by the Division of Behavioral Health and Recovery:

(You may attach additional information if needed)

NAME OF PERSON REQUESTING FAIR HEARING (Appellant)

ADDRESS OF APPELLANT	CITY	STATE	ZIP CODE
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TELEPHONE NUMBER (INCLUDE AREA CODE)

DSHS/CHA CLIENT ID (if known)

REGIONAL SUPPORT NETWORK (if known)

I am represented by: (if you are going to represent yourself do not fill in the next two lines):

YOUR REPRESENTATIVE'S NAME	ORGANIZATION	TELEPHONE NUMBER
----------------------------	--------------	------------------

ADDRESS	CITY	STATE	ZIP CODE
---------	------	-------	----------

Do you need an interpreter or other assistance or accommodation for the hearing?
____ Yes ____ No

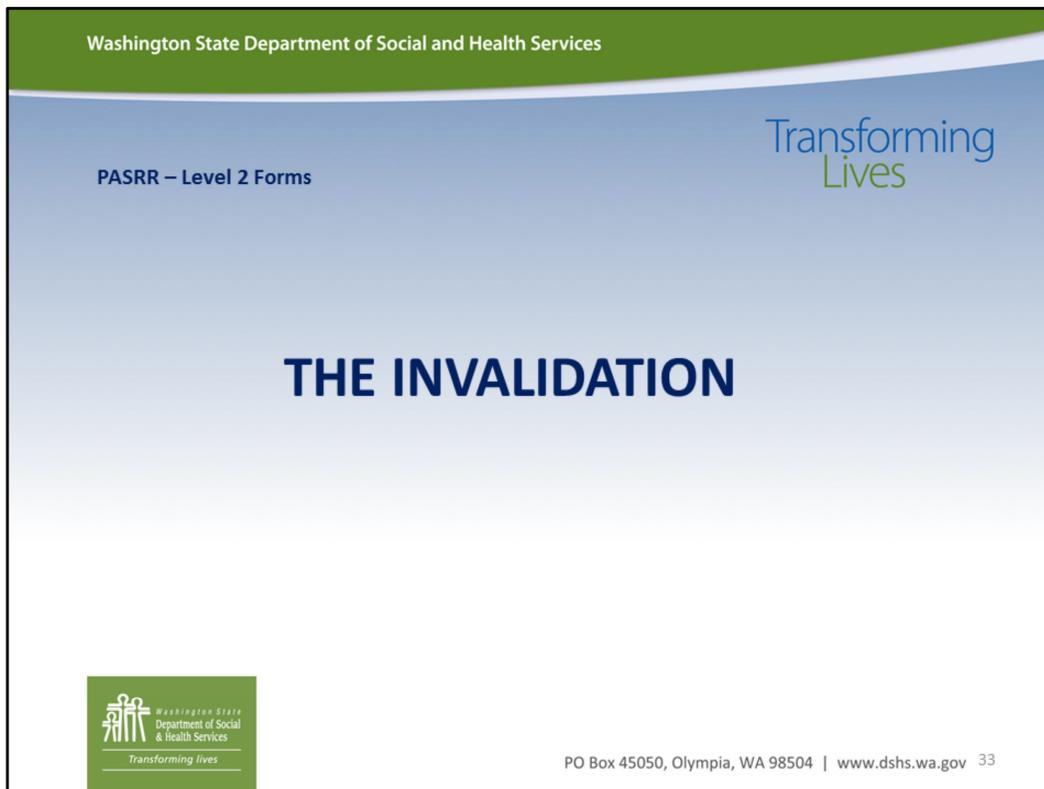
If yes, what language or assistance? _____

You can receive assistance and support with your Fair (Administrative) Hearing from an Ombuds close to where you live. For information about how to contact the Ombuds office in your area, please call the Division of Behavioral Health and Recovery (DBHR) Office of Consumer Partnerships at: 1-800-446-0259 Ext.4

Page 4 of 4



These are instructions now included as part of the NOD on how to request a fair hearing.



We will now go over the INVALIDATION portion of the Level 2 process-

This form is to be used when an evaluator determines that a resident or nursing facility applicant, who has been identified as **positive** on a PASRR Level 1 screen, does not require a Level 2 Psychiatric Initial Evaluation or Follow-up. If an individual meets the criteria for serious mental illness he or she **must** be provided with an evaluation unless any one of the following **invalidating conditions** applies to that individual.

Washington State Department of Social and Health Services

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PASRR – Level 2 Forms
Invalidation



DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
Level 2
Preadmission Screen and Resident Review (PASRR)

Invalidation

This form is to be used when an evaluator determines that a resident or nursing facility applicant, who has been identified as **positive** on a PASRR Level 1 screen, does not require a Level 2 Psychiatric Initial Evaluation or Follow-up. If an individual meets the criteria for serious mental illness he or she **must** be provided with an evaluation unless any one of the following invalidating conditions applies to that individual.

DATE OF REFERRAL
DATE OF INVALIDATION
DATE OF BIRTH

NAME: LAST FIRST MIDDLE

Current nursing facility resident
NURSING FACILITY PLACEMENT AND MAILING ADDRESS:

Preadmission
NAME OF SITE OF INVALIDATION:

A Level 2 Initial Psychiatric Evaluation or Follow-Up is NOT required because of the following reasons:

Categories for Invalidation:



PO Box 45050, Olympia, WA 98504 | www.dshs.wa.gov 34

DATE BOXES

Date of Referral - Write/type in the date the referral was made to contractor.

Date of Invalidation - Write/type in the date the evaluation was completed or attempted.

Date of Birth - Write/type in the date of birth of the individual.

NAME

Write/type in the last name of the individual-check correct spelling.

Write/type in the first name of the individual-check correct spelling.

Write/type in the middle name/initial of the individual-check correct spelling.

If the individual does not have a middle name, leave it blank.

NURSING FACILITY PLACEMENT AND MAILING ADDRESS

If the individual is currently in a nursing facility, check the “Current nursing facility resident” box and

provide the name, and complete address of the facility.

Check the Preadmission box if the individual has not yet been placed in a Nursing Facility.

Inform

discharge staff to include the Invalidation in the discharge packet of information sent to the nursing facility.

Washington State Department of Social and Health Services

PASRR – Level 2 Forms
Invalidation-Cont.

Transforming Lives

Categories for Invalidation

1. The individual has been discharged out of the nursing facility.

2. The individual has a primary diagnosis of severe medical illness which results in a level of impairment so severe that he/she could not be expected to benefit from specialized behavioral health treatment.
List severe medical diagnoses:

3. The individual has a diagnosis of a major neurocognitive disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders DSM), because he/she meets all five of the following criteria (A through E) for major neurocognitive disorder as indicated below.

4. The individual appears to exhibit symptoms of a major neurocognitive disorder:

A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function, and
2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).

5. The individual DOES have one (or more) serious mental illness (SMI) diagnosis.
List diagnoses and DSM code(s):

AND does not have symptoms of serious mental illness as described on the following page in the CRITERIA FOR SEVERITY OF SYMPTOMS.

LEVEL 2 PASRR INVALIDATION
DSHS 14-413 (REV. 02/2016) (AC 02/2016)

Page 1 of 2

PO Box 45050, Olympia, WA 98504 | www.dshs.wa.gov 35

Check **at least one** category of invalidation that disqualifies the individual for a Level 2 Initial Psychiatric Evaluation. Invalidation **must** be completed within 7 days of the referral as required in CFR, and in **DSHS PASRR** contract.

Check box 1 if the individual
Has been discharged. This includes transfers to another facility, home or death of the individual.

Check box 2 if the individual
Has a severe medical illness as the primary diagnosis
The diagnosis results in a level of impairment so severe that he/she could not be expected to benefit from specialized behavioral health treatment
List severe medical diagnoses

Check box 3 if the individual has
A diagnosis of a major neurocognitive disorder

Check box 4 if the individual
APPEARS to exhibit symptoms of a major neurocognitive disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) See form for symptom criteria

Check box 5 if the individual
has been has been diagnosed with at least one serious mental illness **AND does not** have symptoms of serious mental illness as described in the **CRITERIA FOR SEVERITY OF SYMPTOMS** listed on page 2 of the form

List all diagnoses using the most current DSM

PASRR – Level 2 Forms
Invalidation-Cont.

CRITERIA FOR SEVERITY OF SYMPTOMS

Level of impairment: The degree of symptoms of the mental disorder has resulted in functional limitations in major life activities within the past six months that were not appropriate for the person's developmental state. An individual typically has at least one of the following characteristics on a continuing or intermittent basis.

- 1) Interpersonal functioning. The individual has serious difficulty interacting appropriately and communicating effectively with other individuals; has a possible history of altercations, evictions, or loss of employment, fear of strangers; avoidance of interpersonal relationships and social isolation. The individual may be at risk of harm to self or others.
- 2) Concentration, persistence and pace. The individual has serious difficulty in sustaining focused attention and concentration in order to complete simple tasks commonly found in activities of daily living. The individual requires assistance or makes frequent errors in task completion.
- 3) Adaptation to change. The individual has serious difficulty in adapting to change, manifested by agitation, exacerbated by signs and symptoms of illness, withdrawal from the situation, or requiring intervention by mental health or judicial system due to difficulties in adapting to change.



CRITERIA FOR SEVERITY OF SYMPTOMS:

Check box 5 if the individual

has been has been diagnosed with at least one serious mental illness **AND**

does not have symptoms of serious mental illness as described in the

CRITERIA FOR SEVERITY OF SYMPTOMS listed on page 2 of the form

List all diagnoses using the most current DSM

PASRR – Level 2 Forms
Invalidation-Cont.

Evaluator Comments

Evaluator Information



Evaluator Comments:

Use the space provided to document related information to confirm individual's ineligibility for a Level 2 Evaluation. Include comments from the staff and family as appropriate.

PASRR – Level 2 Forms
Invalidation-Cont.

Evaluator Information	
SIGNATURE:	DATE:
PRINT NAME:	TITLE:
CONTRACTOR:	COUNTY:
NAME OF INDIVIDUAL:	

LEVEL 2 PASRR INVALIDATION
DSHS 14-413 (REV. 02/2016) (AC 02/2010)

Page 1 of 2



Evaluator Information:

SIGNATURE - Sign the form

DATE - Date of signature

PRINT NAME and TITLE

CONTRACTOR - If you are working for a contractor, write in the name of the contractor

COUNTY - Where the Invalidation was completed

NAME OF INDIVIDUAL - May auto fill but needs to be completed to verify individual in case pages are separated

PASRR – Level 2 Forms
Invalidation-Cont.

DISTRIBUTION

Upon completion of Level 2 Invalidation-

- *Immediately* send a copy to the Nursing Facility or hospital discharge staff.
- The Invalidation must be included in the individual's clinical record
- Original Invalidation is to remain with contractor/evaluator records.
- Invalidation with Category 1 Discharge - **Send a copy of the Invalidation to the facility of discharge. DO NOT** send a copy to DBHR. Category 1 - discharge will not be reimbursed.
- All other Invalidation - Submit to DBHR with a completed A19 Invoice for processing and payment.



Distribution of the Document as listed on this slide

THE FOLLOW-UP OR SIGNIFICANT CHANGE IN CONDITION



This psychiatric evaluation is intended to be filled out when individual's currently residing in a Medicaid certified nursing facility that since their last Level 2 evaluation have had a significant change in condition or are in need of a follow-up Level 2 evaluation. Based on the diagnosis and need for treatment, if any, a new determination will be made regarding the most appropriate placement and plan of care.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

		DIVISION OF BEHAVIORAL HEALTH AND RECOVERY Level 2 Preadmission Screen and Resident Review (PASRR) Follow-up or Significant Change Psychiatric Evaluation Summary		ASSESSMENT CATEGORY (CHECK APPROPRIATE BOX) <input type="checkbox"/> Follow-up <input type="checkbox"/> Significant Change <input type="checkbox"/> Medicaid Covered Individual DATE OF PREVIOUS LEVEL 2 OR SIGNIFICANT CHANGE
The following psychiatric evaluation is required by OBRA 1987 for persons currently residing in a Medicaid certified nursing facility that since their last Level 2 evaluation have had a significant change in condition or are in need of a follow-up Level 2 evaluation. Based on the diagnosis and need for treatment, if any, a new determination will be made regarding the most appropriate placement and plan of care.				
NAME: LAST		FIRST		MIDDLE
NURSING FACILITY PLACEMENT AND MAILING ADDRESS:				
REASON FOR REFERRAL: (CURRENT SYMPTOMS AND BEHAVIORS THAT HAVE CHANGED SINCE LAST PASRR LEVEL 2)				
PASRR Rights reviewed with individual: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Individual agreed to evaluation: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:				
SITE OF EVALUATION: <input type="checkbox"/> Home <input type="checkbox"/> Nursing facility <input type="checkbox"/> Community facility <input type="checkbox"/> Psychiatric inpatient setting <input type="checkbox"/> General medical hospital setting <input type="checkbox"/> Other (specify):				
NAME OF SITE OF EVALUATION:				
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female		PRIMARY LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Other (specify):		
RACE / ETHNICITY: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> White, not of Hispanic origin		MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Unknown		PRIMARY LIVING SITUATION DURING THE PAST YEAR: <input type="checkbox"/> Home <input type="checkbox"/> Other psychiatric inpatient <input type="checkbox"/> Nursing facility <input type="checkbox"/> Mental Health residential <input type="checkbox"/> Homeless <input type="checkbox"/> Developmental Disability facility <input type="checkbox"/> State Hospital <input type="checkbox"/> Other residential program <input type="checkbox"/> Other (specify):



You will find this form very similar to the Initial Psychiatric Evaluation Summary with only a few differences. It should be very familiar to use.

Instructions how to use this form:

ASSESSMENT CATEGORY BOX

One box **must** be marked; Follow-up **or** Significant Change in Condition
 If individual is covered by Medicaid, check the box.

DATE BOXES

Date of Previous LEVEL 2 - Type in the date the previous Level 2 was completed **or**
 Date of significant change in condition - *as noted by facility staff and/or the individual's support network.*

Date of Referral – Type in the date the referral was made.

Date of Evaluation- Type in the date the evaluation was completed or attempted.

Date of Birth - Type in the date of birth of the individual.

NAME

Type in the last name of the individual - check correct spelling

Type in the first name of the individual - check correct spelling.

Type in the middle name/initial of the individual - check correct spelling.

If the individual does not have a middle name, leave it blank.

NURSING FACILITY PLACEMENT AND MAILING ADDRESS

Type in the name and address of skilled nursing facility where the individual is residing.

REASON FOR REFERRAL

List current symptoms and behaviors that have changed **since the last PASRR Level 2.**

List all current symptoms and behaviors that lead to the referral for Significant Change
List reasons including any symptoms and behaviors for the need to complete a Follow-up.

PASRR RIGHTS

Review PASRR rights with the individual and check the box.

Did the individual agree to the PASRR evaluation - Check the appropriate box. Make any appropriate comments regarding their willingness to participate in the comment box.

SITE OF EVALUATION

Check appropriate box indicating the location of where the evaluation was completed. If other, write in location site.

NAME OF SITE OF EVALUATION

Type in name of location where evaluation was conducted.

GENDER

Check appropriate box – what gender the individual self identifies as.

PRIMARY LANGUAGE

Check appropriate box. Specify other primary language.

RACE/ETHNICITY

Check appropriate box.

MARITAL STATUS

Check appropriate box.

PRIMARY LIVING SITUATION DURING THE PAST YEAR

Check the appropriate box. If other, specify other living situation.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

1. Diagnosis Indicated by Present Evaluation	
DSM:	
Medical:	
Psychiatric Diagnoses of record:	
PRINT NAME OF PERSON COMPLETING EVALUATION:	TITLE:
SIGNATURE OF PERSON COMPLETING EVALUATION:	DATE:
CONTRACTOR:	



Complete the following sections with emphasis on changes in the individual’s condition since the previous Level 2 evaluation. Include any staff and individual’s support network observations.

Section 1.

List all diagnosis indicated by the present evaluation using the most current DSM (**you must include the correct code**)

List all applicable medical diagnoses.

List all psychiatric diagnoses of record.

PRINT NAME and TITLE

SIGNATURE – Sign and write in the date form was completed.

CONTRACTOR – If you are working for a contractor, write in the name of the contractor.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

Comments / Recommendations of the Reviewing Psychiatrist	
SIGNATURE OF REVIEWING PSYCHIATRIST:	DATE:
DEPARTMENT OF SOCIAL AND HEALTH SERVICES – DBHR DESIGNEE'S SIGNATURE:	DATE:

LEVEL 2 PASRR INITIAL PSYCHIATRIC EVALUATION
DSHS 14-338 (REVISED – 04/2016) Page 1 of 3



Write recommendations or comments related to the completed evaluation here. **To be completed only by the reviewing psychiatrist.** This is the portion is intended for the SNF staff and is to be reviewed by the SNF staff for implementation of any identified specialized services for incorporation into the individuals plan of care.

SIGNATURE

Sign and write in the date upon completion of psychiatric review.

Department of Social and Health Services/DBHR Designee

Sign and date upon completion.

Washington State Department of Social and Health Services

Transforming Lives

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

<p>2. Recommendations for Plan of Care</p> <p><input type="checkbox"/> Follow-up Evaluation Date: <input type="checkbox"/> No Follow-up Evaluation needed (Unless significant change in condition occurs while in nursing facility)</p> <p>A. Mental Health Services: provide explanation for recommended service(s):</p> <p><input type="checkbox"/> 1. Acute psychiatric hospitalization (The mental health needs of the individual cannot be met at the skilled nursing facility):</p> <p><input type="checkbox"/> 2. Specialized services can be provided in a skilled nursing facility by a licensed mental health professional or mental health agency for:</p> <p><input type="checkbox"/> a. Individual Services, i.e., case management, therapy, case consultation for:</p> <p><input type="checkbox"/> b. Psychiatric assessment and medication evaluation / management for:</p> <p><input type="checkbox"/> 3. No mental health services are recommended at this time (explain below):</p> <p>B. Recommendations for Nursing Facility: (include likes and dislikes about people, and community environments, what helps keep them calm):</p> <p><input type="checkbox"/> 1. Environmental</p> <p><input type="checkbox"/> 2. Staff approaches / training:</p> <p><input type="checkbox"/> 3. Behavioral supports:</p> <p><input type="checkbox"/> 4. Activities:</p> <p><input type="checkbox"/> 5. Other:</p> <p>C. Other Medical Services:</p> <p><input type="checkbox"/> 1. Psychiatric medication management as currently provided by the individual's primary physician (non-psychiatrist).</p> <p><input type="checkbox"/> 2. Medical assessment to address the following physical health symptoms:</p> <p><input type="checkbox"/> 3. Ancillary services (podiatry, PT, dental, etc.):</p> <p>D. Recommendations for Community Transition:</p> <p>1. Is it possible for this individual to reside in the community and have their needs met?</p> <p>2. Individual's stated preference of living situation in community:</p> <p>3. Evaluator recommendations for community transition:</p>
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Follow-up evaluation date

Check the appropriate box. If a follow-up evaluation is needed, indicate a **date** to follow-up.

A. MENTAL HEALTH SERVICES - Check the appropriate box. Provide a specific explanation.

- 1. Acute psychiatric hospitalization** - if checked, the MH needs of the individual cannot be met at the SNF. Notify staff as appropriate.
- 2. Specialized services** - check the appropriate box - (a and/or b) and provide specific examples.
- 3. No mental health services** are needed - Explain why.

B. RECOMMENDATIONS FOR NURSING FACILITY -

This section is to provide the nursing facility staff with information to help them meet the mental health needs of the individual while they are in the nursing facility.

Check applicable boxes (1-5).

Write your recommendations in a manner that is appropriate for all levels of nursing facility staff. Be descriptive. Ask **“person centered”** questions that include likes and dislikes about people, and community environments, and what helps to keep them calm. Recommendations **must** be specific to the individual.

C. OTHER MEDICAL SERVICES- Check appropriate boxes (1-3).

1. Note any psychiatric medication management currently prescribed.
2. Note any physical health symptoms that may impact their psychiatric condition.
3. Note any ancillary services that will benefit the individual during their nursing facility stay.

D. RECOMMENDATIONS FOR COMMUNITY TRANSITION –

1. Note if the individual's current needs could be met in the community.
2. Note individual's stated preference of living situation in community.
3. Note specific recommendations that will help to facilitate a potentially successful transition into the community.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

3. Presenting Problem(s)
A. Current psychiatric problems and status:
B. Recent relevant events since previous PASRR Level 2 Evaluation: (list changes in condition, either improvement or decline)
C. Behavioral and emotional problems:
D. Interview and Impressions:



- A.** List current symptoms and behaviors as exhibited during interview, conversations with staff and medical record information as noted in the chart.
- B.** List reasons for hospitalization and/or nursing facility placement.
- C.** List behaviors and emotional problems exhibited during interview and self-reported by the individual and/or as reported by staff.
- D.** This is where information you observed and gathered during the interview is written and interpreted. Write your conclusions in a manner that is appropriate for all levels of nursing facility staff. Note any discrepancies between what is documented as opposed to what is observed.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

4. Psychiatric History		
A. Psychiatric history: (include history of suicide attempts and risk of harm to self or others)		
B. Date of onset of psychiatric symptoms: <input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 – 5 years <input type="checkbox"/> More than 5 years <input type="checkbox"/> Unknown		
C. Psychiatric hospitalizations:		
Within past two years:		Total during lifetime:
<input type="checkbox"/> None	<input type="checkbox"/> 1 – 5 hospitalizations	<input type="checkbox"/> None
<input type="checkbox"/> More than 5 hospitalizations	<input type="checkbox"/> Unknown	<input type="checkbox"/> 1 – 5 hospitalizations
<input type="checkbox"/> Unknown		<input type="checkbox"/> More than 5 hospitalizations
<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown
D. Provide information of psychiatric hospitalizations (reason, location, dates, course of treatment) with emphasis on most recent hospitalization:		
E. History of previous medications with response/lack of response: (if known)		
F. Current mental health services provider / Behavioral Health Organization (BHO) / agency name and telephone number:		
NAME: LAST	FIRST	DATE OF BIRTH
LEVEL 2 PASRR INITIAL PSYCHIATRIC EVALUATION		Page 2 of 3
DSHS 14-338 (REVISED – 04/2016)		



- A.** List all psychiatric history. Include inpatient treatment, outpatient treatment, any suicide attempts, or risk of harm to self or others.
- B.** Onset of Psychiatric Symptoms - Check appropriate box
- C.** Psychiatric Hospitalizations - Check appropriate boxes
- D.** List reasons and course of treatment during psychiatric hospitalization(s) with emphasis on most recent.
- E.** History of previous medications-List any known history or adverse reactions or failed trials to any psychiatric medications.
- F.** Current MH services-List current mental health provider if known and Behavioral Health Organization.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

5. Substance Use History	
A. Is there history or current use of alcohol or substances for this individual?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
C. Substance use disorder questionnaire attached:	<input type="checkbox"/> Yes <input type="checkbox"/> No Comments:



- A.** Is there a history or current use of substance or alcohol for this individual? Check appropriate box.
- B.** If yes, specify substances, dates and circumstances on form.
- C.** If yes, **complete Substance Use Disorder Questionnaire and attach with evaluation. (see previous slide)**

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

6. Family History
A. Family history of mental illness? (note relationship):
B. Family history of suicide? (note relationship):
C. Family history of alcohol/substance abuse? (note relationship): Comments:



- A.** Is there a family history of mental illness for the individual? If yes, note relationship.
- B.** Is there a family history of suicide for the individual? If yes, note relationship.
- C.** Is there a family history of substance use for the individual? If yes, note relationship.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

7. Current Medical Information and Medications

- A. Attach copies of laboratory reports, consultations, recent medical notes and the comprehensive history and physical examination and medical diagnoses list for psychiatric review.
- *Required contents as necessary to determine diagnoses:** complete medical history; review of all systems; specific evaluation of the individual's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes; and in case of abnormal finding(s), which are the basis for a NF placement, additional evaluation conducted by appropriate specialists.
- B. Attach copies of medication use profile: for purposes of psychiatric review, record medication, copy of the current physicians orders. Specify additions / changes for all medications, including frequency of PRN medications, during the past 90 days.
- C. List current psychotropic medications:



- A.** Attach copies of all supporting medical documentation as listed on the form. **This documentation must accompany the evaluation for psychiatric review.**
- B.** Attach copies of medication use profile as listed on the form. Attach a copy of the current physician orders. Specify additions or changes for all medications, including frequency of PRN medications, during the past 90 days. **This documentation must accompany the evaluation for psychiatric review.**
- C.** List all psychotropic medications. **This documentation must accompany the evaluation for psychiatric review.**

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

8. Psychological Test Instruments		
Total Score:	Instruments:	Comments:
<input type="text"/>	Mini Mental Status Exam (MMSE)	<input type="text"/>
<input type="text"/>	Geriatric Depression Scale (GDS)	<input type="text"/>
<input type="text"/>	Brief Psychiatric Rating Scale (BPRS)	<input type="text"/>
<input type="text"/>	Mood Disorder Questionnaire (MDQ)	<input type="text"/>
Functional assessment: (include review of MDS, any OT, PT, Speech Therapy documentation) <input type="text"/>		
See attachments for complete information.		



Testing Instruments

Complete all appropriate tests as needed documenting score and particular findings in the comment section. If the test is not preformed or does not apply write N/A in score box for each test.

Functional assessment

Include a review of the MDS, and any OT, PT, and Speech Therapy consults. This documentation **must** accompany the evaluation.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

9. Behavioral Health Services			
A. Has the individual requested behavioral health services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what type? Comment: <input type="text"/>
B. Agrees to recommended behavioral health services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Uncertain Comment: <input type="text"/>
C. Does the individual perceive a need for mental health services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comment: <input type="text"/>
D. Were mental health services recommended in the previous Level 2?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please describe: <input type="text"/>
E. If mental health services were received, describe outcome: <input type="text"/>			



- A. Indicate if the individual has requested behavioral health services.
- B. Indicate if the individual agrees to any recommended behavioral health services or if they are uncertain.
- C. Indicate if the individual perceives a need for behavioral health services.
- D. Indicate if the individual had any behavioral health service recommendations in the previous Level 2.
- E. Describe the outcome of any behavioral health services received in the comments box.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

10. Additional Information		
A. Strengths and assets: (according to evaluation findings) <input type="text"/>		
B. Individual's stated goals: <input type="text"/>		
C. Have there been significant changes in their support network since the last PASRR? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what kind? Comment: <input type="text"/>		
D. Individual's identified skills, strengths and favorite activities with interests: <input type="text"/>		
NAME: LAST <input type="text"/>	FIRST <input type="text"/>	DATE OF BIRTH <input type="text"/>



- A.** List the individual's strengths and assets according to this assessment and input from others.
- B.** List the individual's goals.
- C.** Identify and list the individual's current support network and adult family situation – List names, relationship, any potential support provided.
- D.** List the individual's self-identified skills, strengths and favorite activities with interests.

PASRR – Level 2 Forms
Follow Up/Significant Change-Cont.

Distribution

Upon completion of Level 2 Follow Up or Significant Change
Psychiatric Evaluation Summary:

- Immediately send two (2) copies of the form and any pertinent medical documentation to the Psychiatrist for psychiatric, quality assessor review, and for DBHR processing.



Distribution of the document as listed on this slide

PASRR – Level 2 Forms

Transforming
Lives

The Interrupted Evaluation (Invalidation)



This form is to be used **only** when a Level 2 Evaluation is terminated.
The invalidation must be sent to the SNF for incorporation into the individual's clinical record.

PASRR – Level 2 Forms
Interrupted Evaluation-Cont.



DIVISION OF BEHAVIORAL HEALTH AND RECOVERY
Level 2
Preadmission Screen and Resident Review (PASRR)
Invalidation
Interrupted Evaluation

DATE OF REFERRAL: []
DATE OF INTERRUPTED INVALIDATION: []
DATE OF BIRTH: []

INSTRUCTIONS: This form is to be used **only** when a Level 2 Evaluation is terminated (see criteria below). **An invalidation must be completed and filed in the patient record.** If the evaluation is terminated after fifteen minutes or more, (not to exceed 60 minutes) this Interrupted Evaluation form should be completed, attached to a copy of the Invalidation, and submitted to DBHR with an A19 voucher.



Type or write in the Date of Referral was made
Type or write in the Date of the Interrupted Invalidation
Type or write in the Individual's date of birth

Washington State Department of Social and Health Services

PASRR – Level 2 Forms
Interrupted Evaluation-Cont.

Transforming Lives

Criteria

The evaluation was terminated after minutes (use 15 minute increments, not to exceed 60 min.)
Check one of the following

did not meet the criteria for serious mental illness; **or**

did meet the criteria for major neurocognitive disorder; **or**

did meet criteria for severe medical illness

Washington State Department of Social & Health Services
Transforming lives

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After beginning the Evaluation and upon interview, your findings reveal that one of the criteria listed on this slide applies,
Write or type in how many 15 minute increments were completed before terminating the interview.

PLEASE NOTE

The Interrupted Invalidation is **not indented to exceed 60 minutes in length or (4) 15 minute increments.**

You should have a good idea before an hour long interview, if you need to complete the more extensive level 2 evaluation or not.

If any of the invalidation criteria apply, check the appropriate box:

PASRR – Level 2 Forms
Interrupted Evaluation-Cont.

Evaluator Information	
SIGNATURE: []	DATE: []
PRINT NAME: []	TITLE: []
CONTRACTOR: []	COUNTY: []



- Sign the form
- Date the form
- Print your name and title
- Provide the name of your contractor if you have one
- List the county where you preformed the Invalidation

PASRR – Level 2 Forms
Interrupted Invalidation-Cont.

Distribution:

An Invalidation must be completed and filed in the patient record.

- If the evaluation is terminated after fifteen minutes or more, (not to exceed 60 minutes)
- The Interrupted Evaluation form must be completed
- Attach it to a copy of the Invalidation, and submit to DBHR with an A19 voucher.



Distribution of this document as listed on this slide

PASRR – Level 2 Forms
Notification to SNFs


STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES Behavioral
Health Administration
Division of Behavioral Health and Recovery
P.O. Box 45330, Olympia, WA 98504-5330

To: Social Services Director
Nursing Facility
Address
City, State, Zip code

From: Sharon L. Rushing, PASRR Program Administrator 

Subject: Preadmission Screen and Resident Review (PASRR) Level 2 Psychiatric Evaluation for (NAME)

In accordance with Preadmission Screen and Resident Review (PASRR) Federal requirements (42 CFR 483.100 – 138) the Division of Behavioral Health and Recovery (DBHR) is forwarding this PASRR Level 2 Evaluation for an individual who resides in your facility or who is being admitted into your facility.

PASRR Level 2 for: (INDIVIDUAL'S NAME)

The following actions need to be taken regarding this evaluation:

For the individual:

- o The nursing facility social work or nursing staff must talk with the individual about this Level 2 PASRR Evaluation and offer the individual an opportunity to read it, discuss it, and receive a copy of it.
- o If the individual agrees to the recommendations included in the evaluation, arrangements need to be made to carry out those recommendations, whether those are provided by/within your facility or in other settings outside of your facility. Individuals with Medicaid may qualify for additional services from the Behavioral Health Organization (BHO) in your county.
- o The PASRR Level 2 evaluation must be included as a permanent part of the individual's medical record. The Notice of Determination that was received at the time of the PASRR interview should also become a permanent part of the individual's record and made available to authorized family members, guardians, or caregivers.

For the individual's clin of care:

- o The evaluation is to be reviewed by the attending physician and appropriate facility staff.
- o The resident's medical record may need to be changed to reflect the individual's mental health diagnosis.
- o The individual's plan of care may need to be amended to include any behavioral health recommendations.

Neither copies of the Level 2 Evaluation nor the information contained within should be provided to anyone who is not authorized to read or receive them.

These documents are confidential medical records.

For follow-up/Significant Change Level 2 PASRRs:

- o You must send a new Level 2 request to the DBHR PASRR contractor to request an updated Level 2 Evaluation.
- o If you have received a follow-up or Significant Change Level 2, that evaluation should be reviewed with the individual, become a part of the individual's medical record, and arrangements should be made to carry out the recommendations that are included in the new evaluation.

For individuals transferred to another skilled nursing facility:

- o Copies of all PASRR documents must be included in the individual's discharge packet.

If you have questions about the recommendations contained in the Level 2 please contact the evaluator who completed the evaluation.



What happens to all of your completed Level 2 Evaluations?

Upon psychiatric and QA review, all PASRR Level 2's are sent to DBHR from the QA reviewer. DBHR enters information into a PASRR database and processes evaluator reimbursements. A copy of each completed Level 2 is sent to the respective skilled nursing facility with a letter from the DBHR PASRR administrator directed to the SNF social work department with instructions as to what they are to do with the PASRR recommendations. DBHR maintains on file a copy of each completed Level 2.

Questions?

Please send them to:

PASRR_Inquiries@dshs.wa.gov



For questions please send them to the PASRR inbox email address on this slide.
All questions will be reviewed and answered as quickly as possible.
This concludes today's PASRR Evaluator Level 2 Training presentation.
Thank you for your participation.