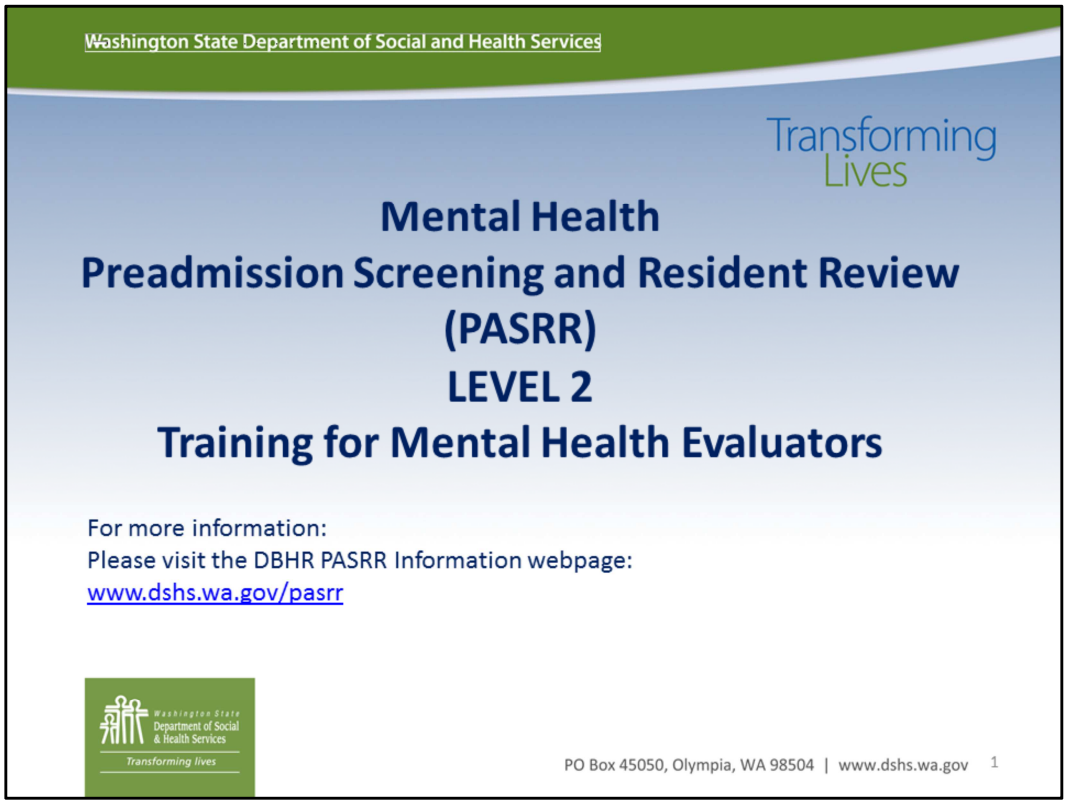



The following training presentation is on recent revisions to the DBHR Mental Health Preadmission screening and resident review (PASRR) Level 2 forms and process.

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.

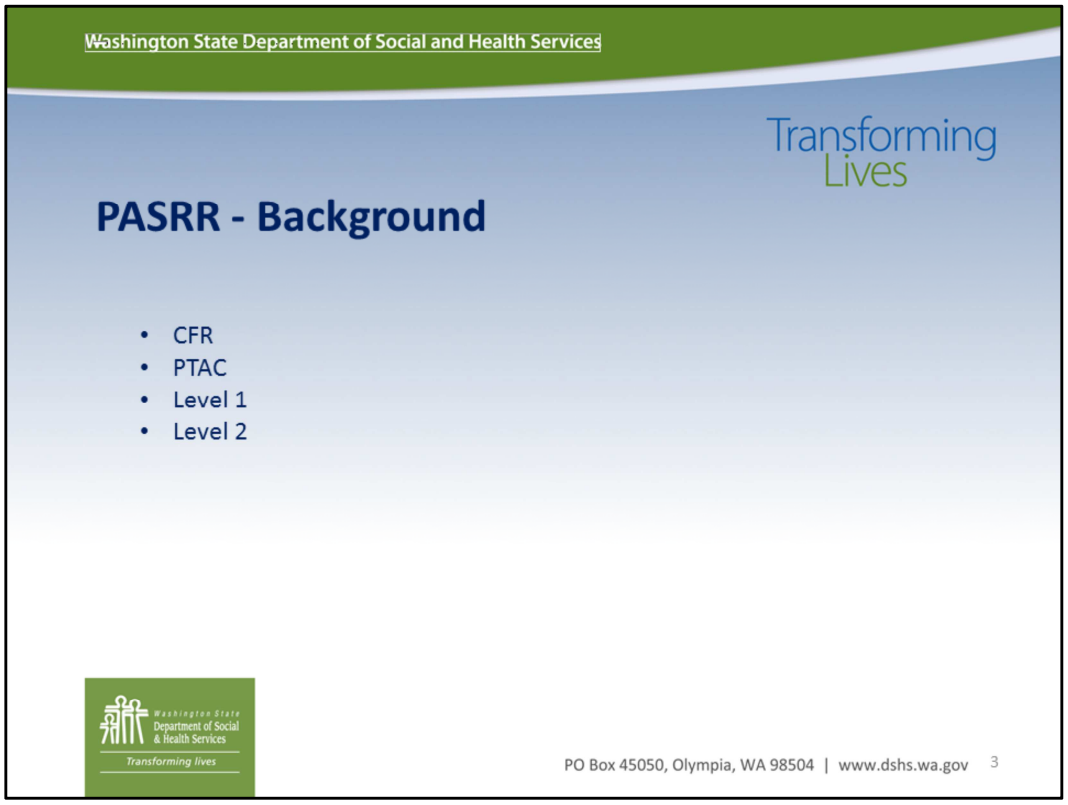

I would like to express sincere appreciation to the PASRR Level 2 workgroup members who worked so very hard to bring us where we are today, they are:

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 inquires, and will be routinely monitored. All questions received will be reviewed and answered as quickly as possible.




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


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.**

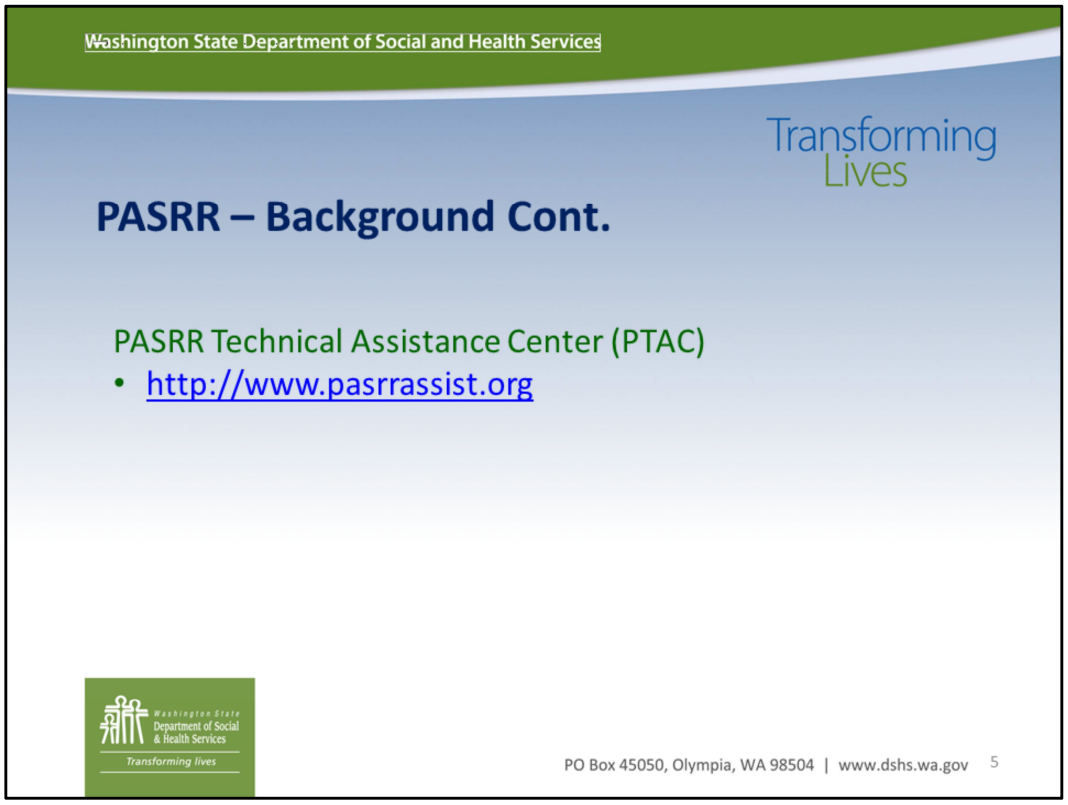
PASRR is intended to:

- 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.




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.

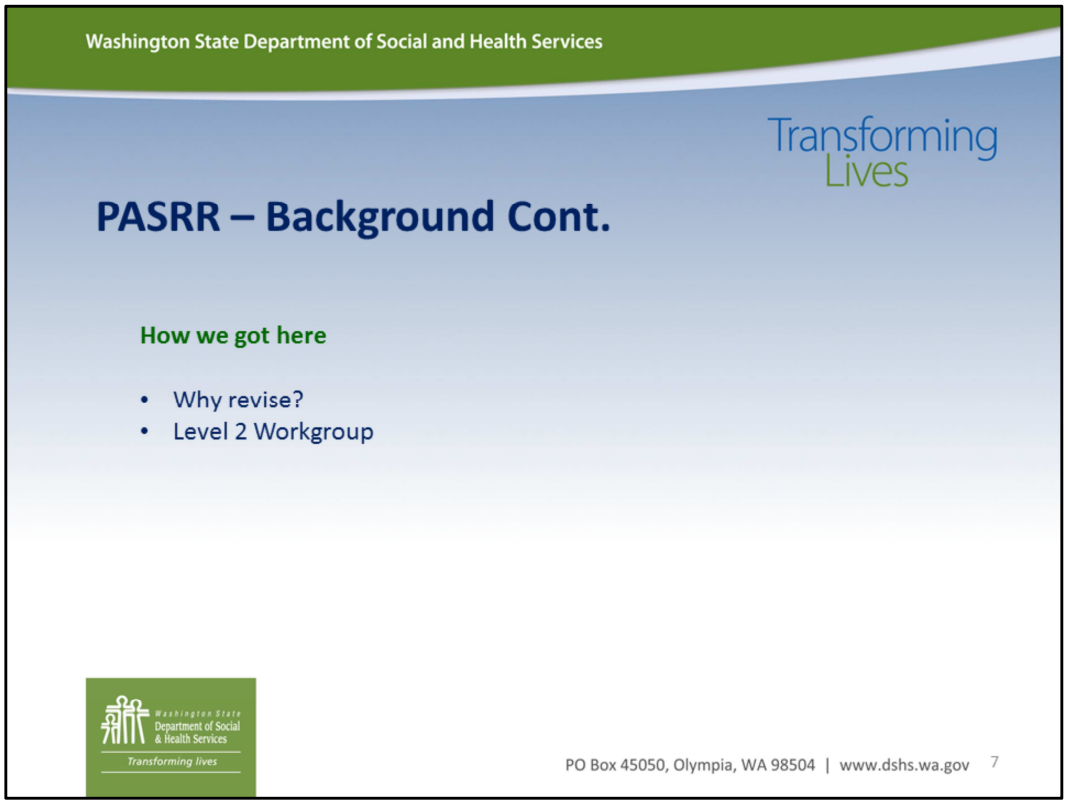

As I mentioned, this training presentation is about the recent revisions to the DBHR PASRR Level 2 forms and what is expected in their use.

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 **P**ASRR. 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.




Why Revise-

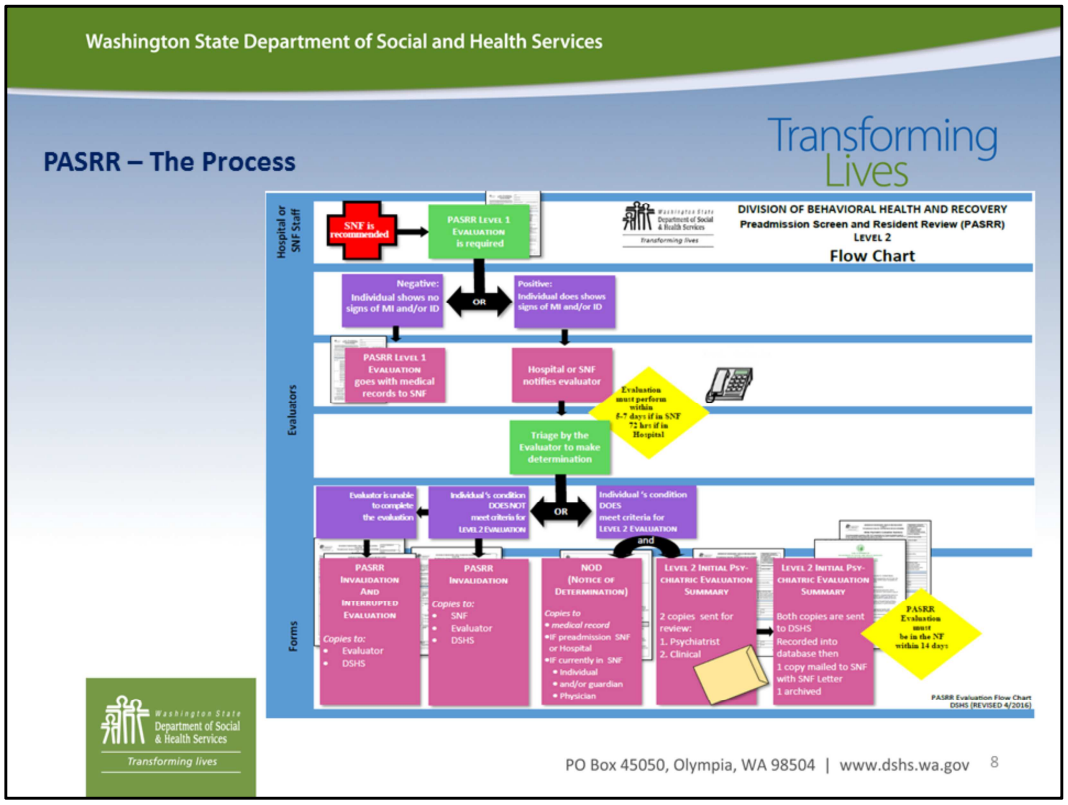
As you know, our previous Level 2 forms required to list multiaxial diagnosis which the DSM 5 has since removed.
And with the implementation of ICD 10 and DSM 5 it became necessary to revise our Level 2 form.

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 Evaluation Flow


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:

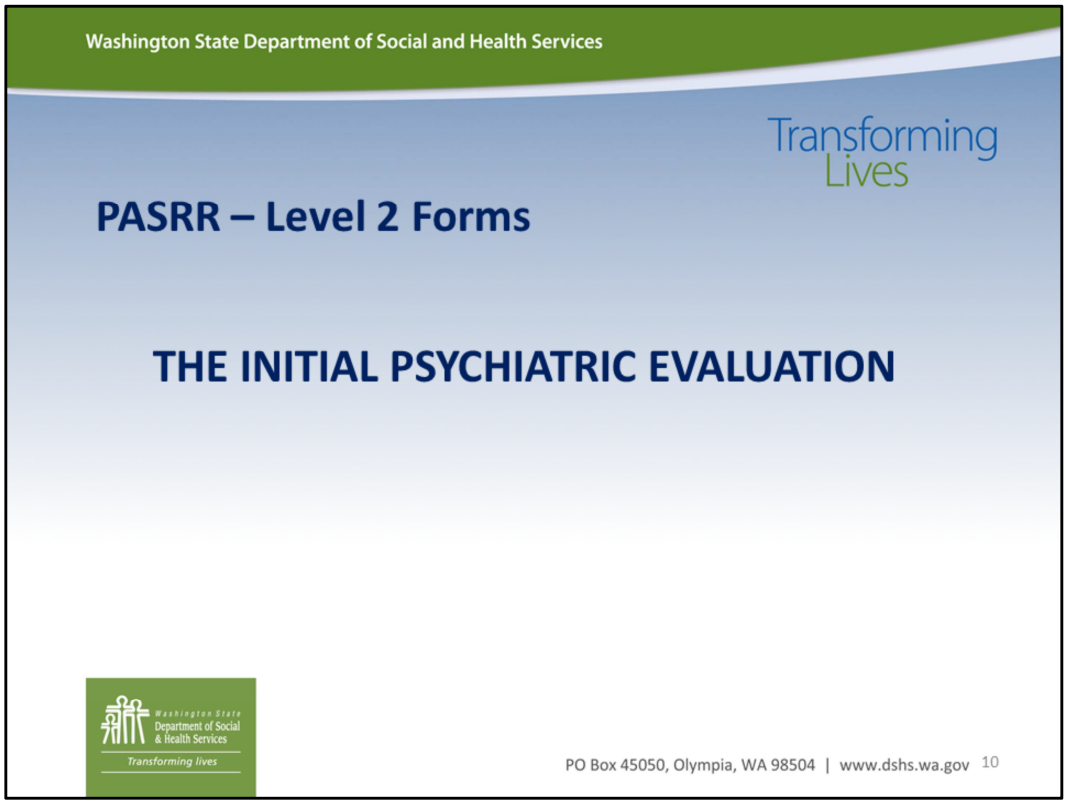
- The Initial Psychiatric Evaluation – A Comprehensive Psychiatric Evaluation that will contain behavioral health service recommendations for the person with an identified SMI. (Completed ***prior*** to admission into a SNF. Usually while at a hospital or by a community physician, HCS or some other community 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.

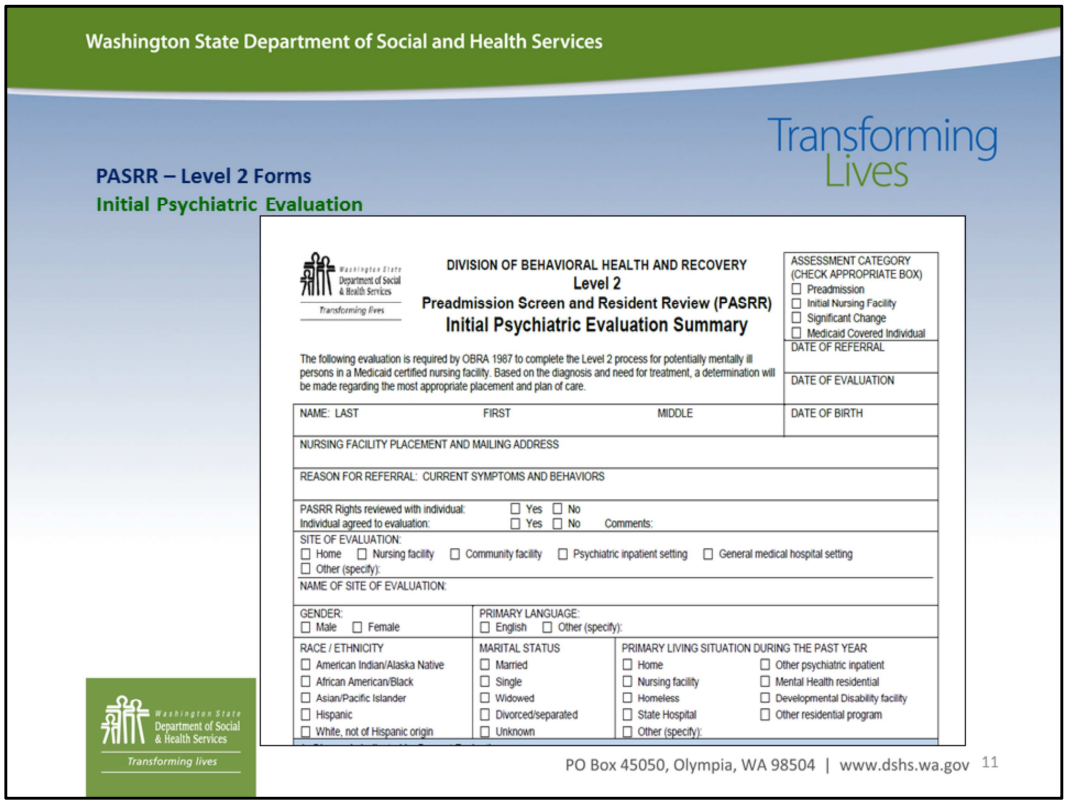
- The Follow-up or Significant Change in Condition – Referral for a change in the individual's previous behavioral health status that requires another full Level 2 Psychiatric Evaluation and any changes to their behavioral health recommendations that will require an update to their plan of care.

- 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.




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.




**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**

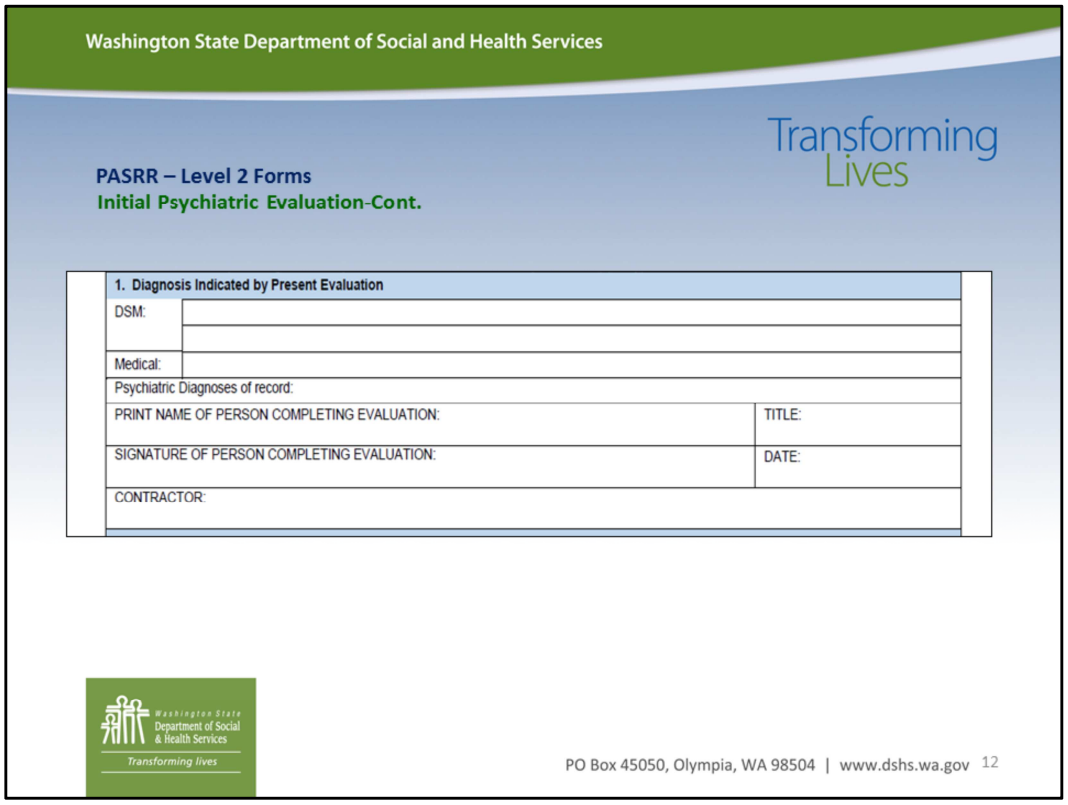
Check appropriate box.

**MARITAL STATUS**

Check appropriate box.

**PRIMARY LIVING SITUATION DURING THE PAST YEAR**

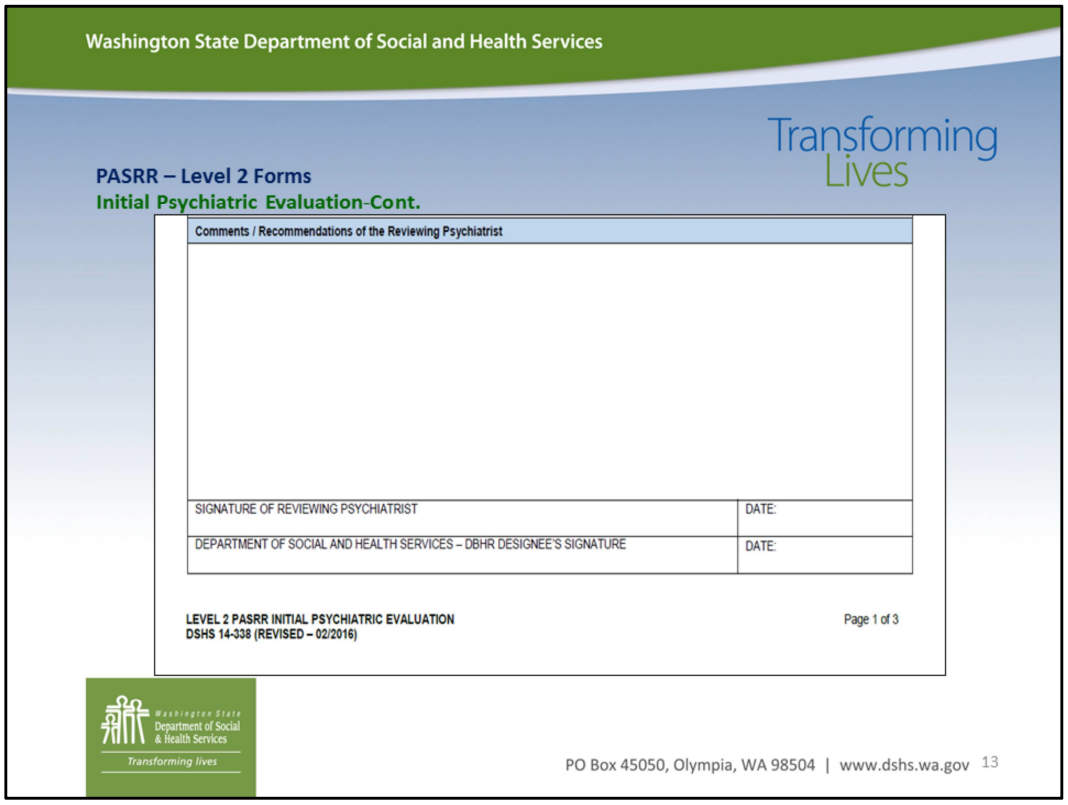
Check the appropriate box. If other, specify other living situation.




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.

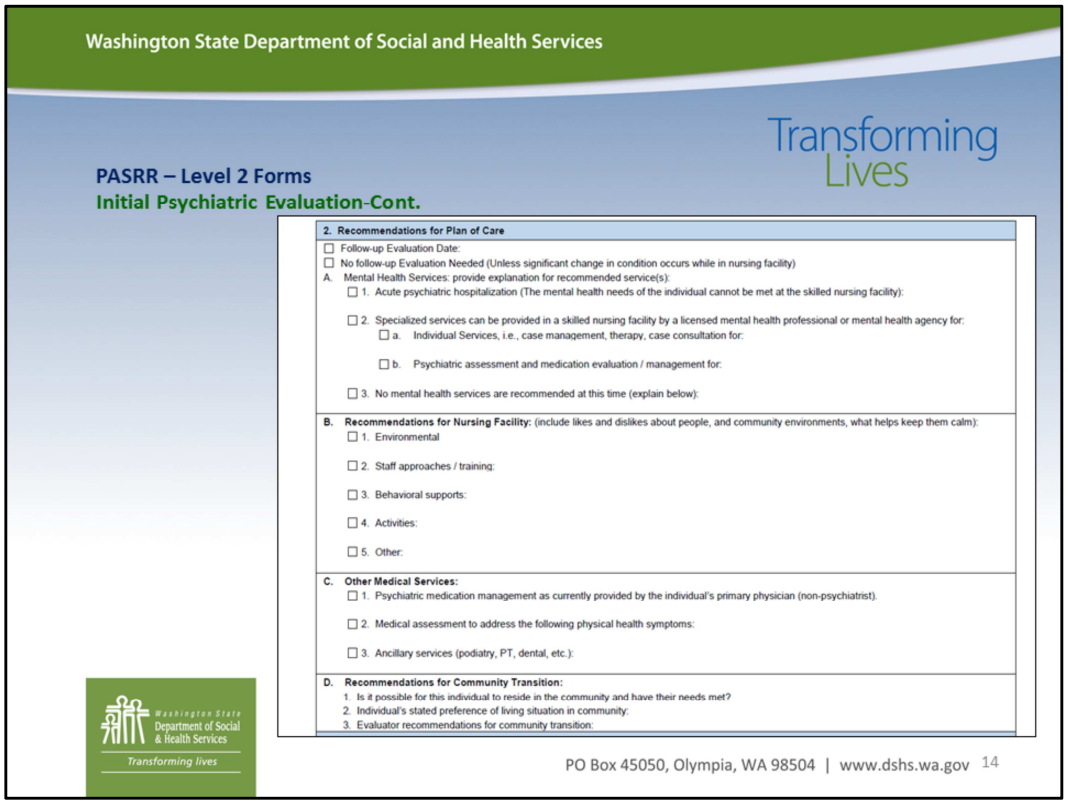



**Comments/Recommendations of the Reviewing Psychiatrist:**

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.




**Section 2. Recommendations for Plan of Care**

**<u>Follow up evaluation date</u>**
**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. **<u>Be descriptive</u>.** Ask **"person centered"** questions that include likes and dislikes about people, and

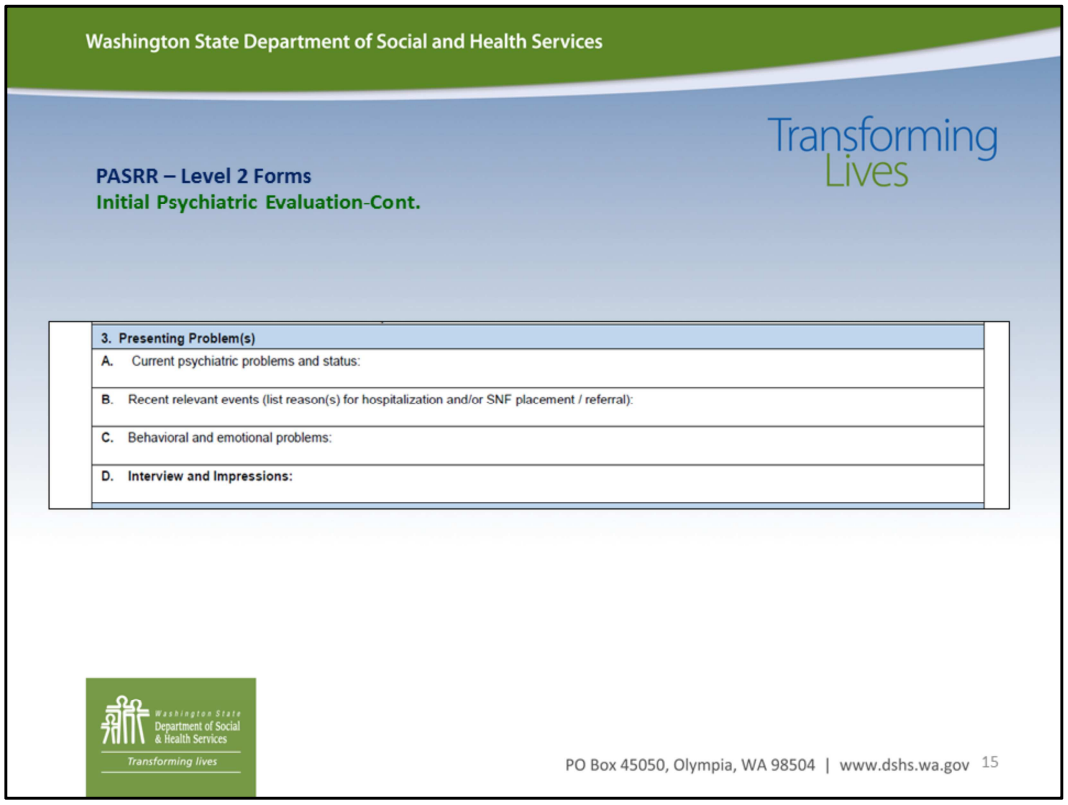
community environments, and what helps to keep them calm. Recommendations ***must*** be specific to
the individual.

**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.



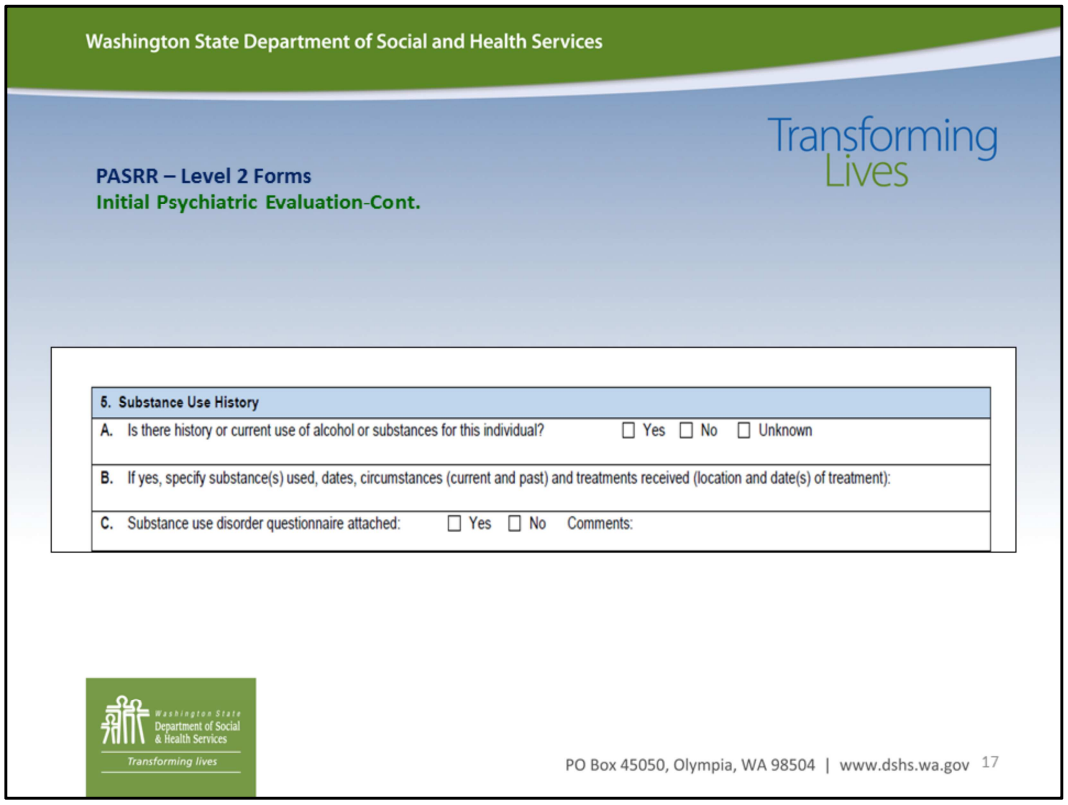

**Section 3. Presenting Problems:**

- 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.

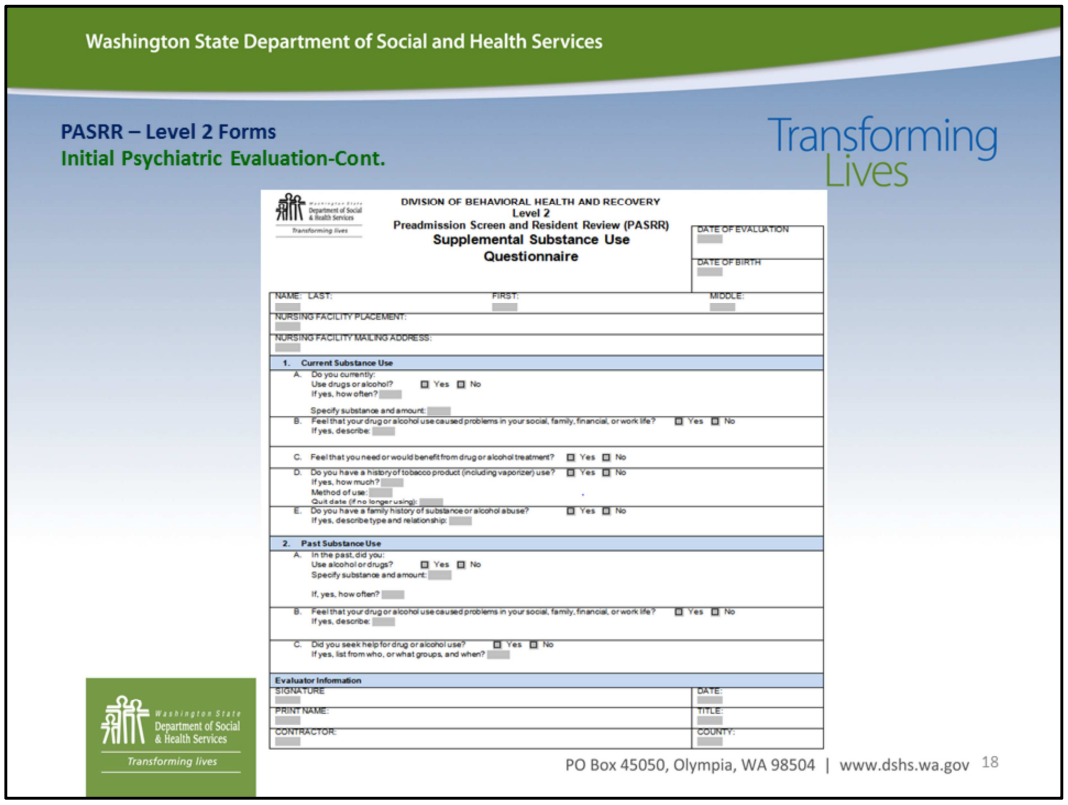

**Section 4. Psychiatric History**

- 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.




Section 5. Substance Use History:

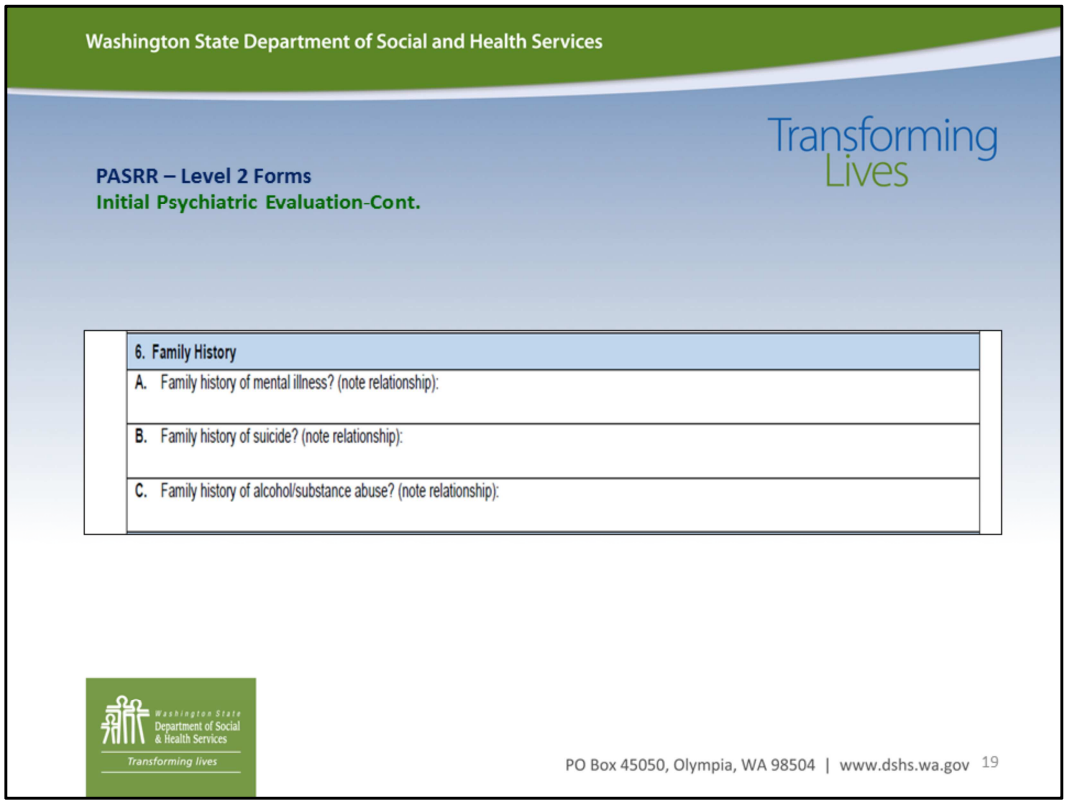
- Is there a history or current use of substance or alcohol for this individual? Check appropriate box.
- If yes, specify substances, dates and circumstances on form.
- If yes, complete substance use disorder questionnaire and attach it with the evaluation.




Substance Use Disorder Questionnaire:

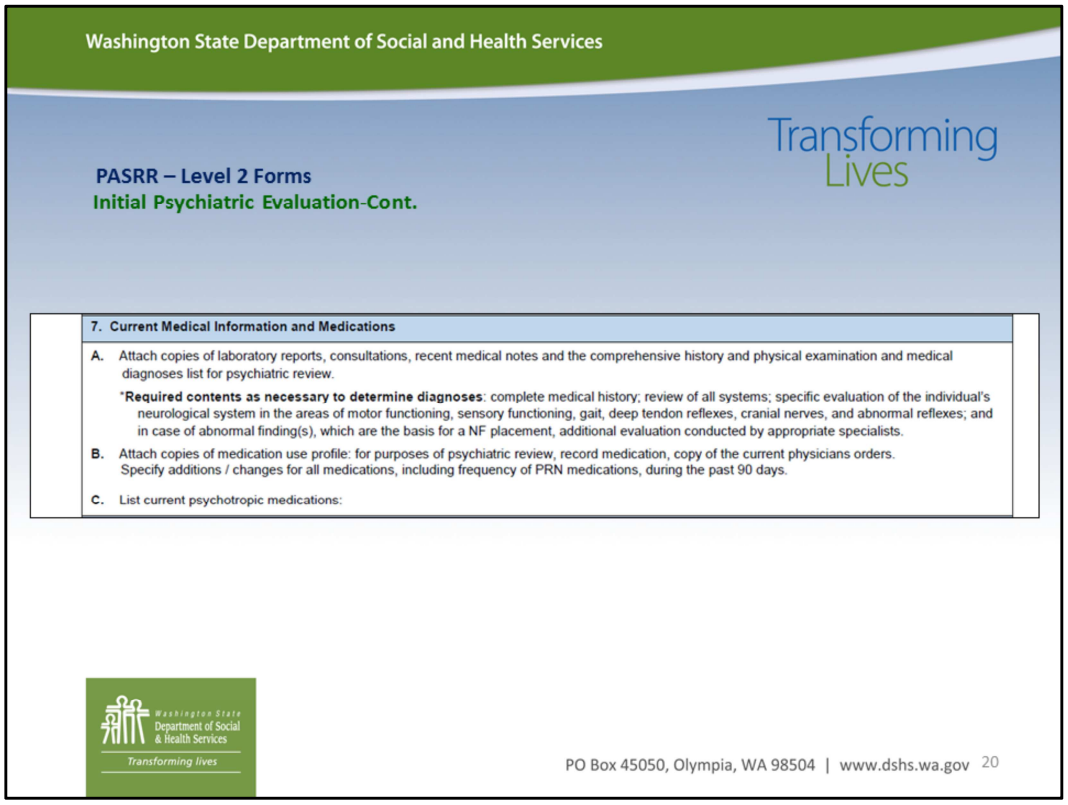
This slide shows the new substance use disorder questionnaire that is to be submitted along with the completed Level 2 evaluation if the individual shows evidence of a possible substance use disorder.

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.




**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.

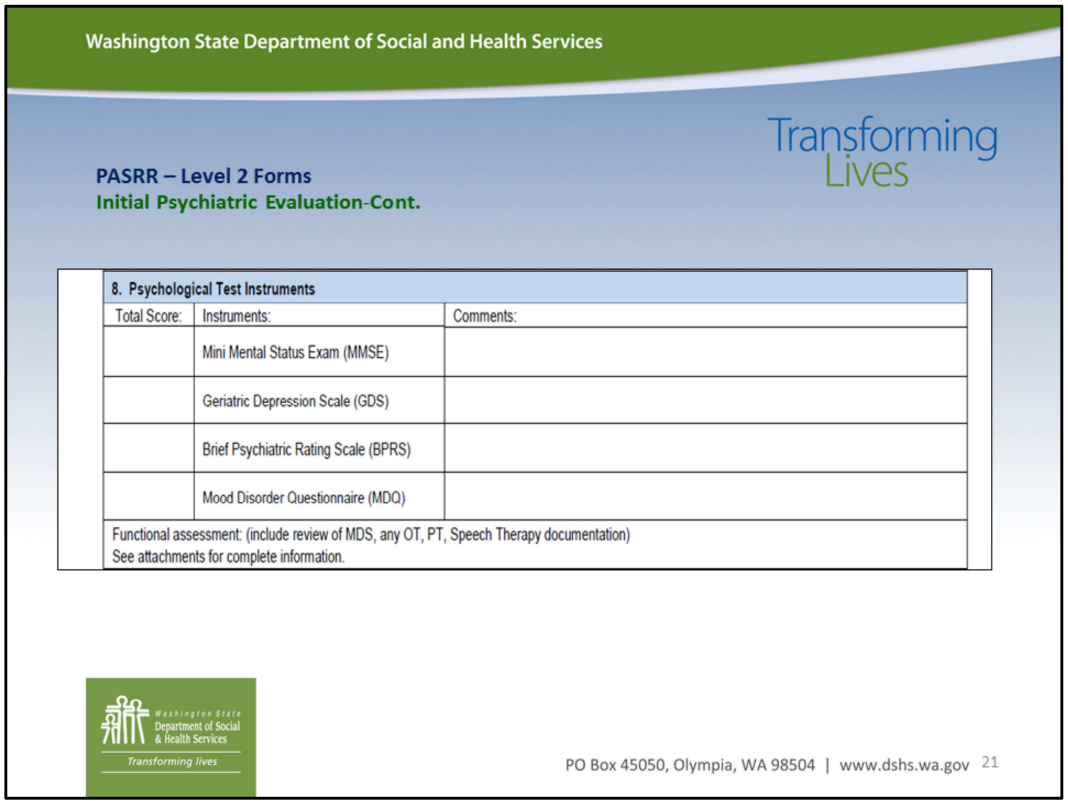



**Section 7. Current Medical Information and Medications:**

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.**



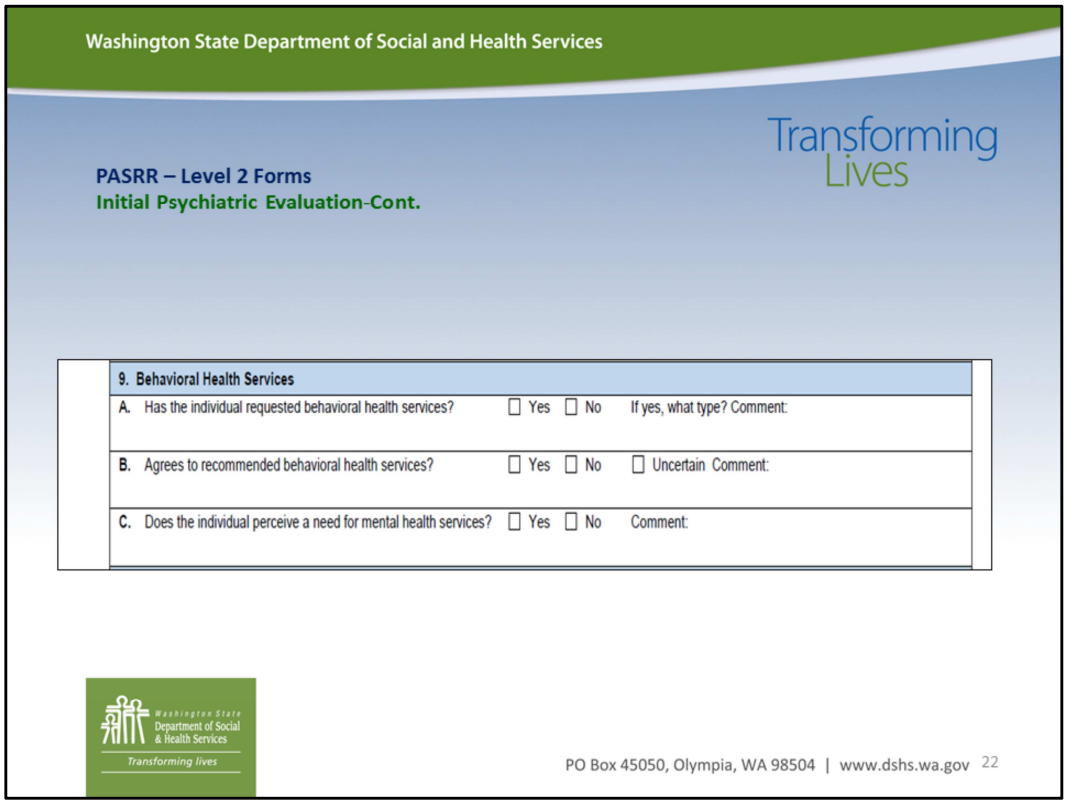

**Section 8 Psychological Test Instruments-**

**<u>Testing Instruments</u>**

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.

**<u>Functional assessment</u>**

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

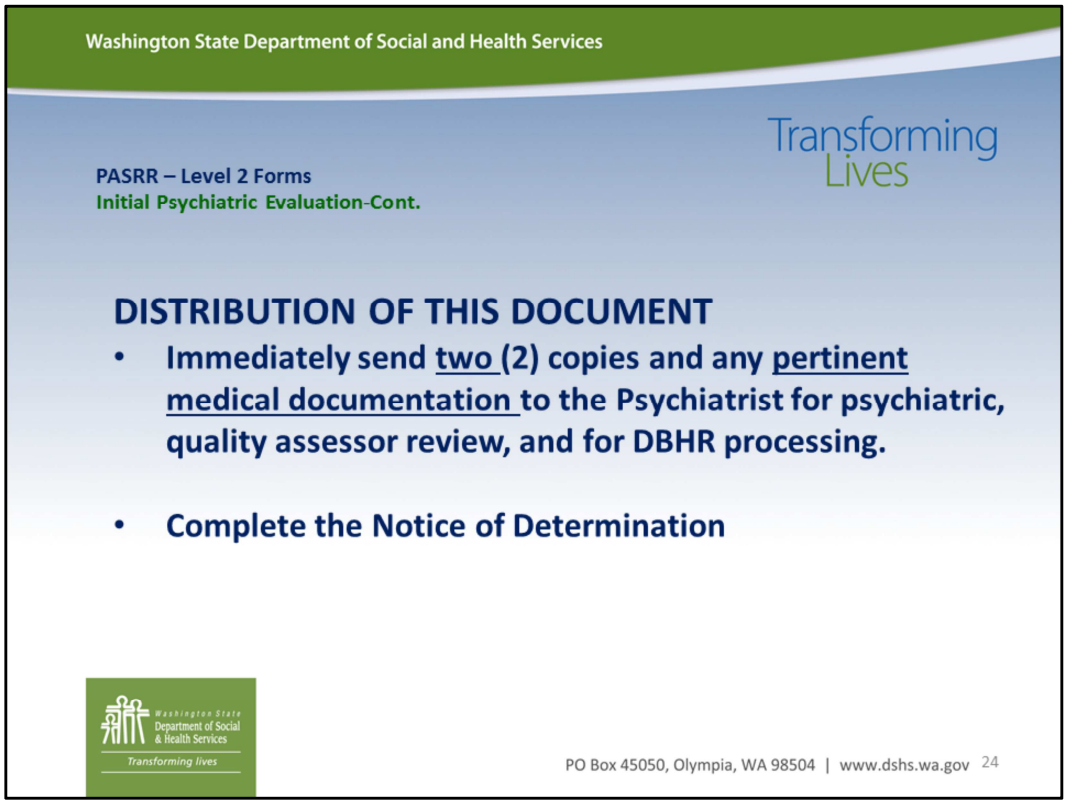



**Section 9. Behavioral Health Services**

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.

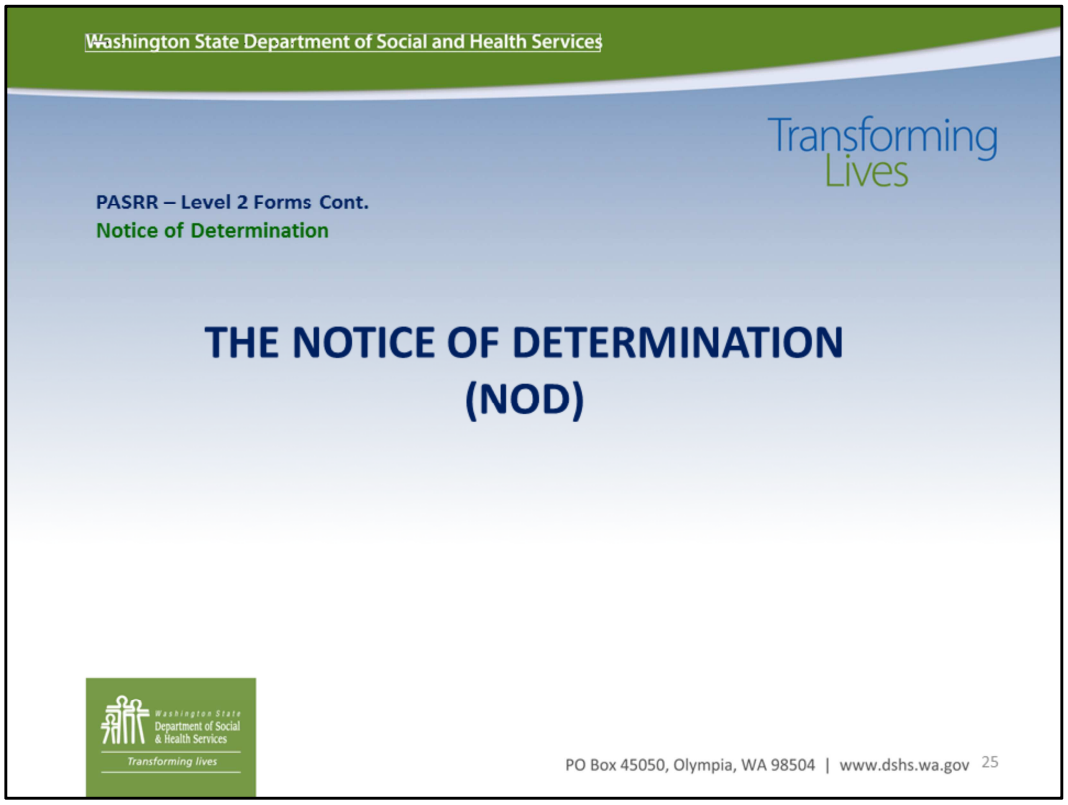

**Section 10.**

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.



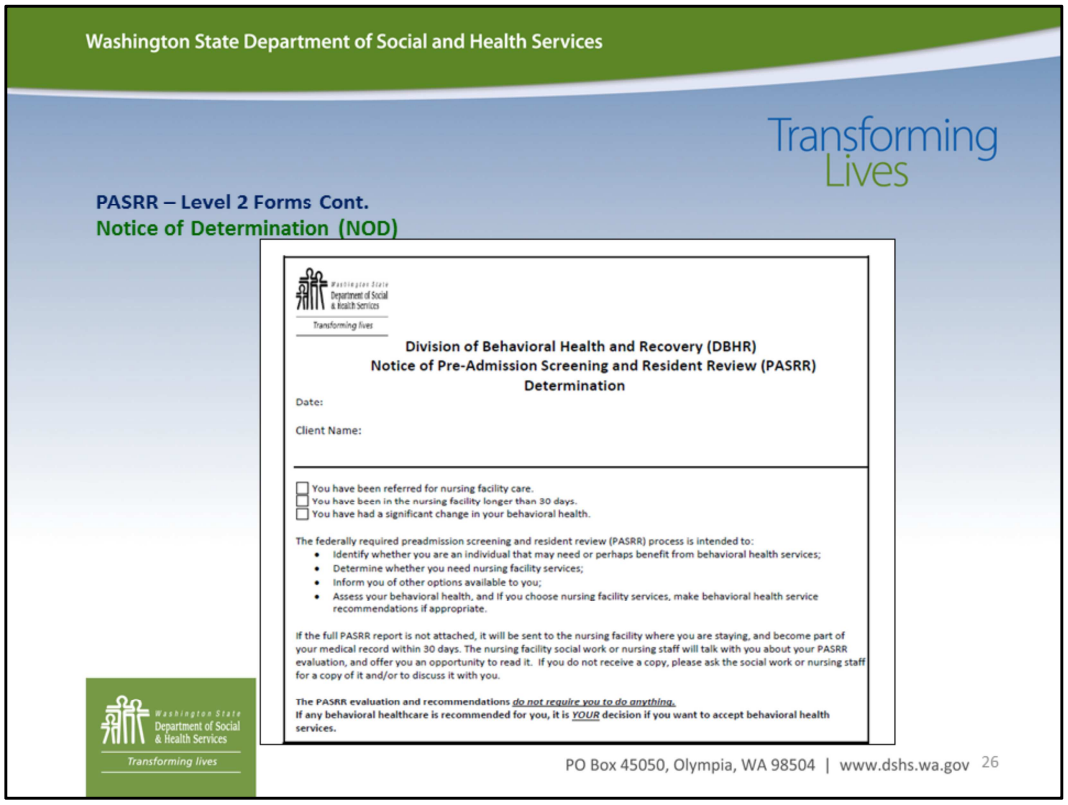

Upon completion of Level 2 psychiatric evaluations, immediately send two (2) copies and any pertinent medical documentation to the Psychiatrist for psychiatric, quality assessor review, and for DBHR processing.

Complete the NOD and distribute as instructed.

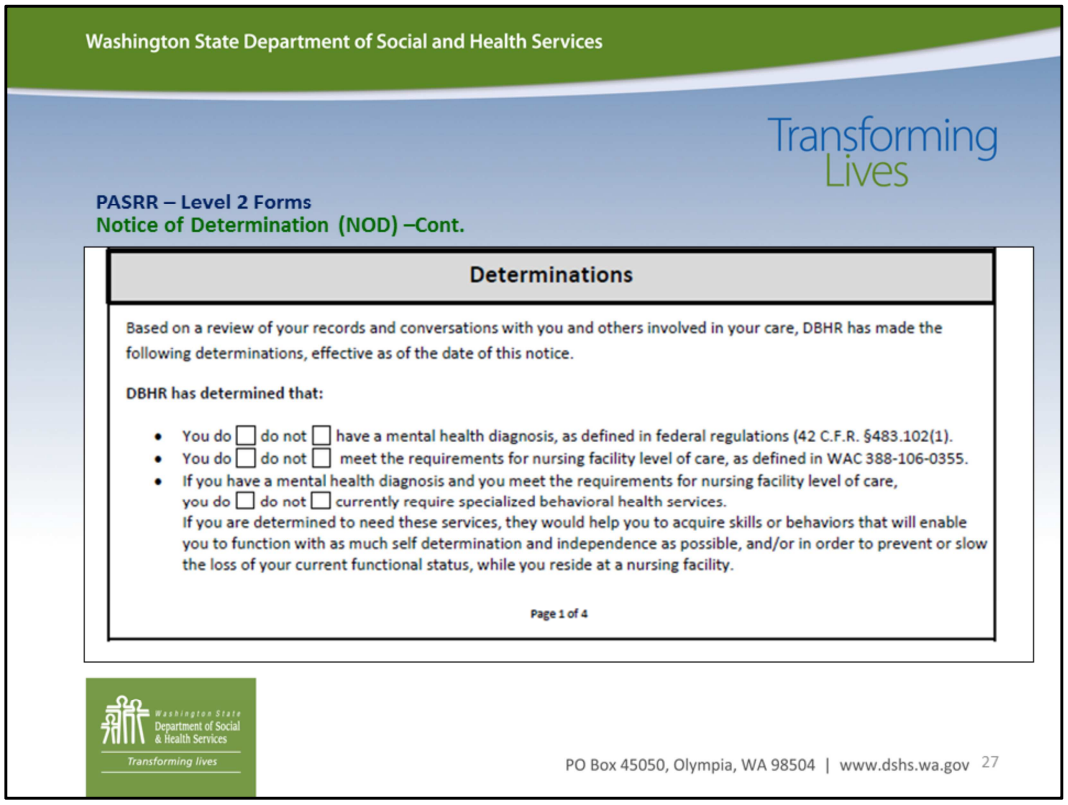



The Notice of Determination
Use this form upon completion of a PASRR Level 2 Initial Psychiatric Evaluation Summary.

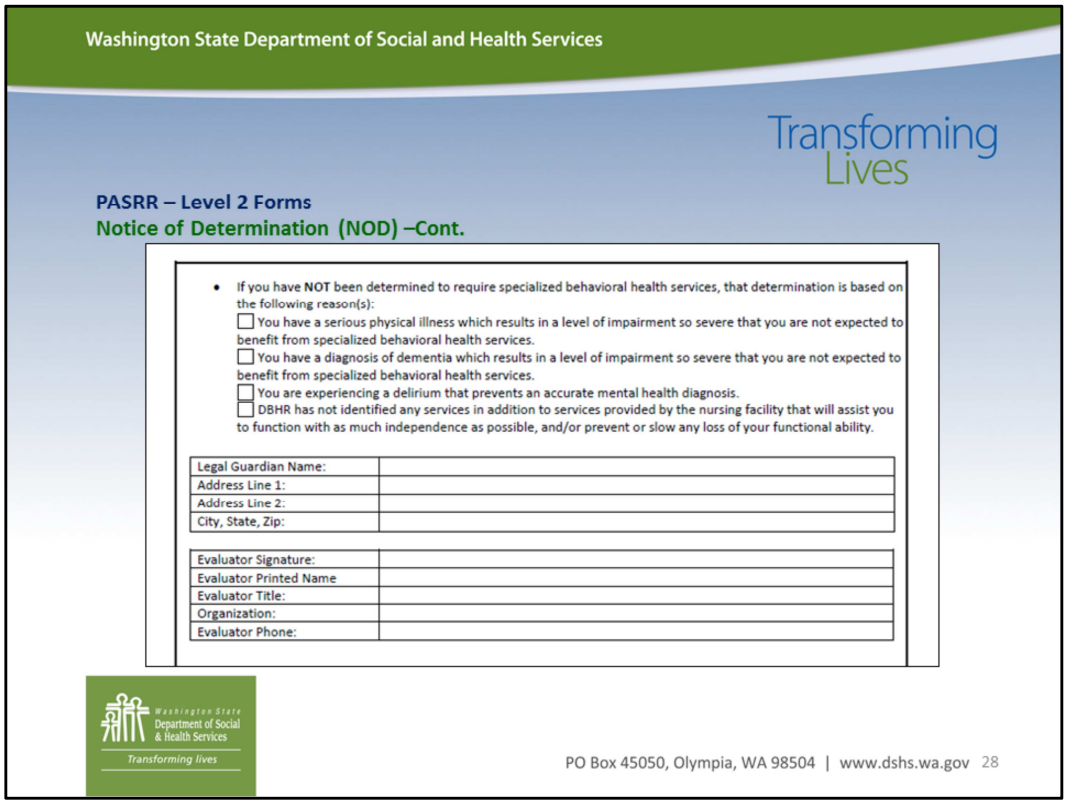
**The purpose of this form:**
To fulfill 42 CFR 483.128 distribution and determination notification requirements when a PASRR Level 2 evaluation has been performed and why.
To provide written notification of the determination(s) made to the client and/or family member and SNF for inclusion into the medical 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




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



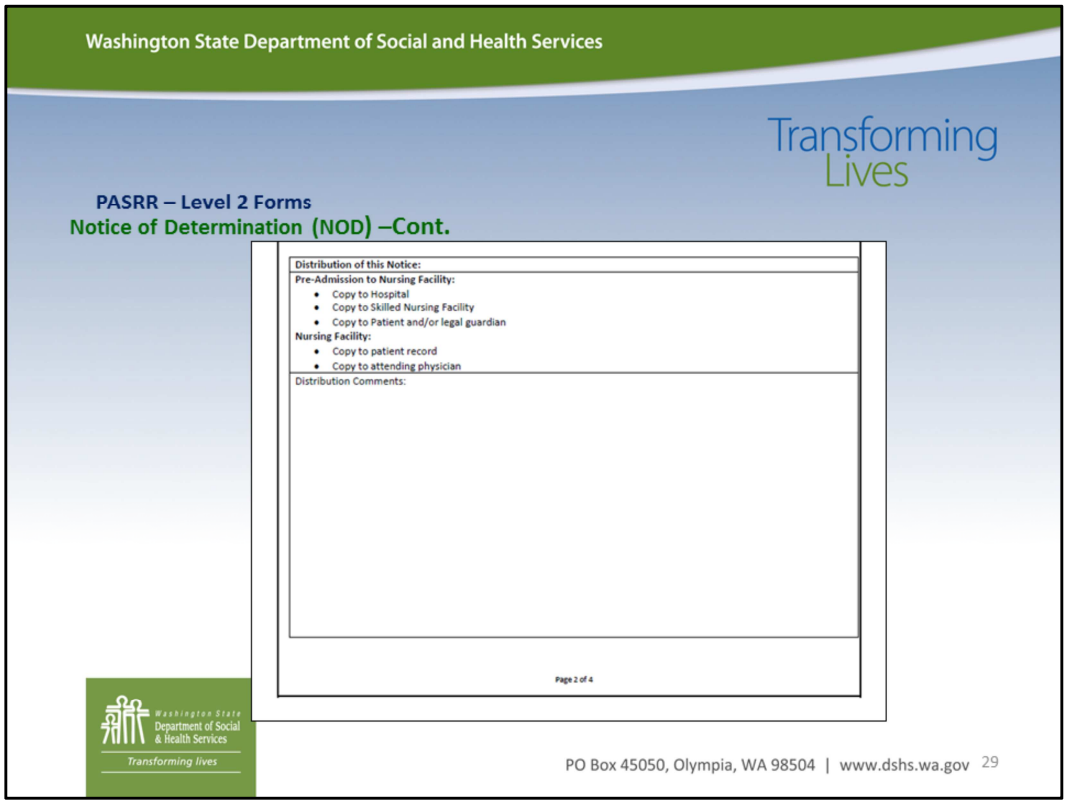

4. Discuss with the client if able (or POA etc.) the intent of the PASRR see bullets on form
**5. *IMPORTANT* *Please discuss with the client that any recommendations from the evaluation do not require them to do anything.* And that If any behavioral healthcare is recommended, it is *THEIR* decision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




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

7. Fill in guardian name etc.

8. Fill in your name etc.




**Please provide a copy of this notice to:**

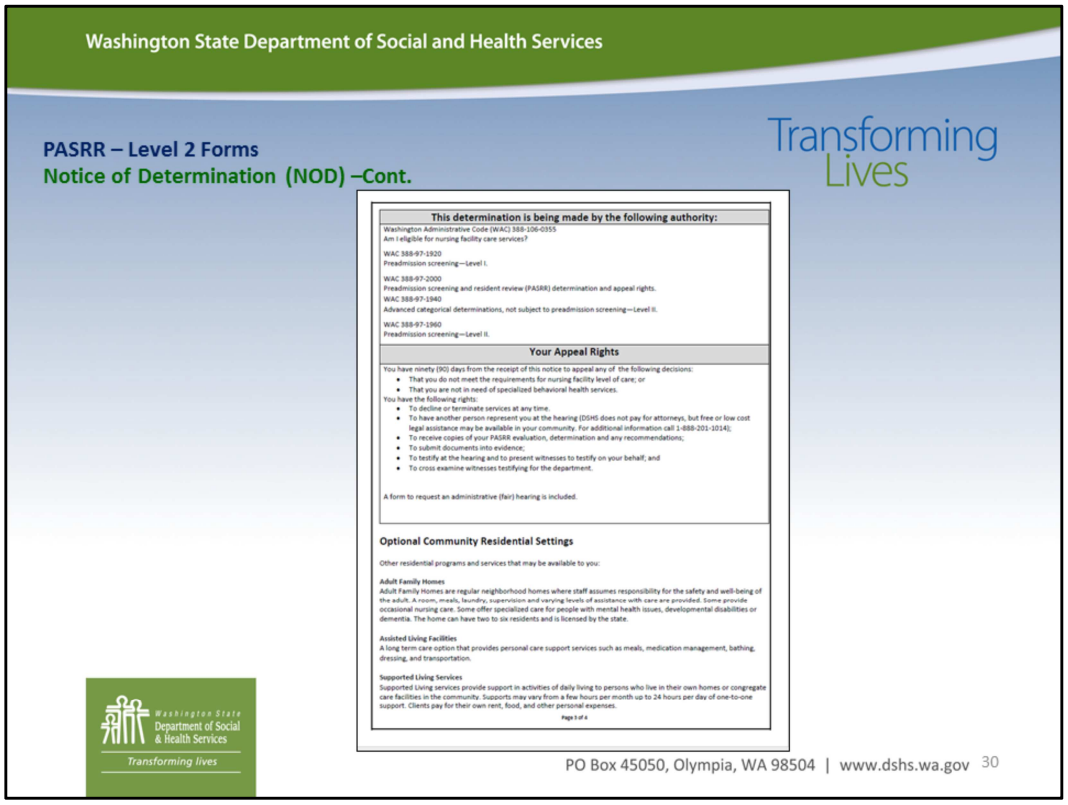
The client (If appropriate and client is willing to accept it)

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

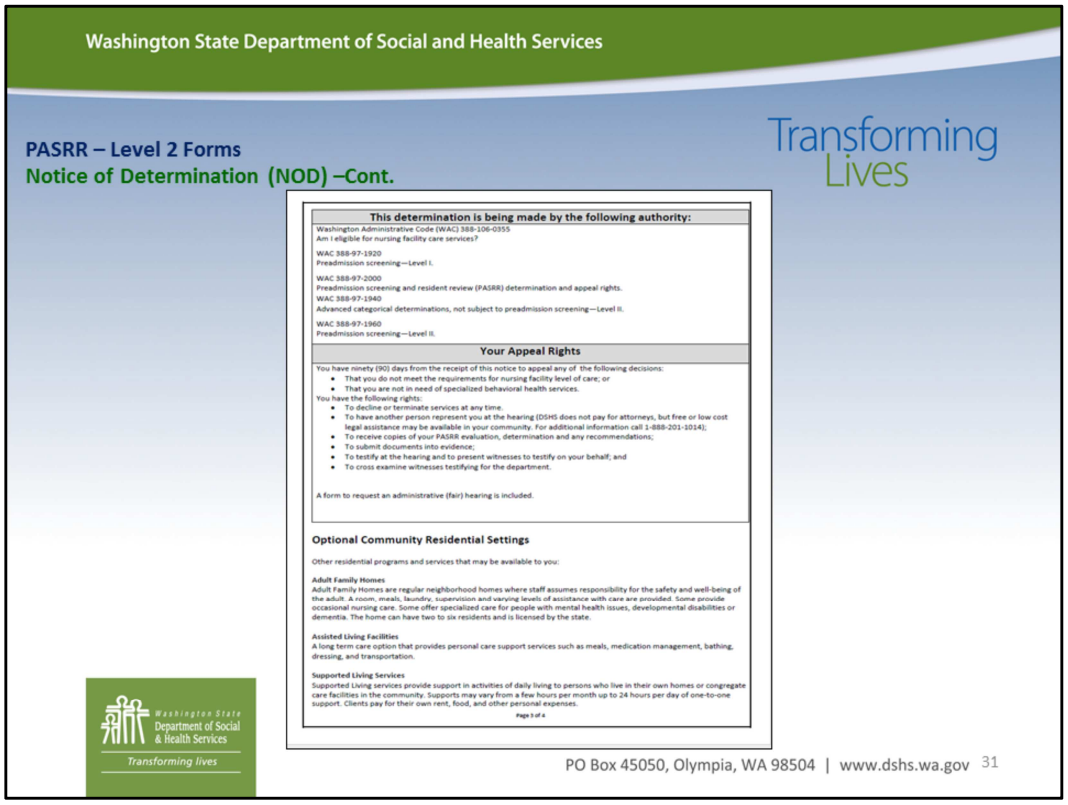
Use the distribution comments section for any additional information that will be helpful to know

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

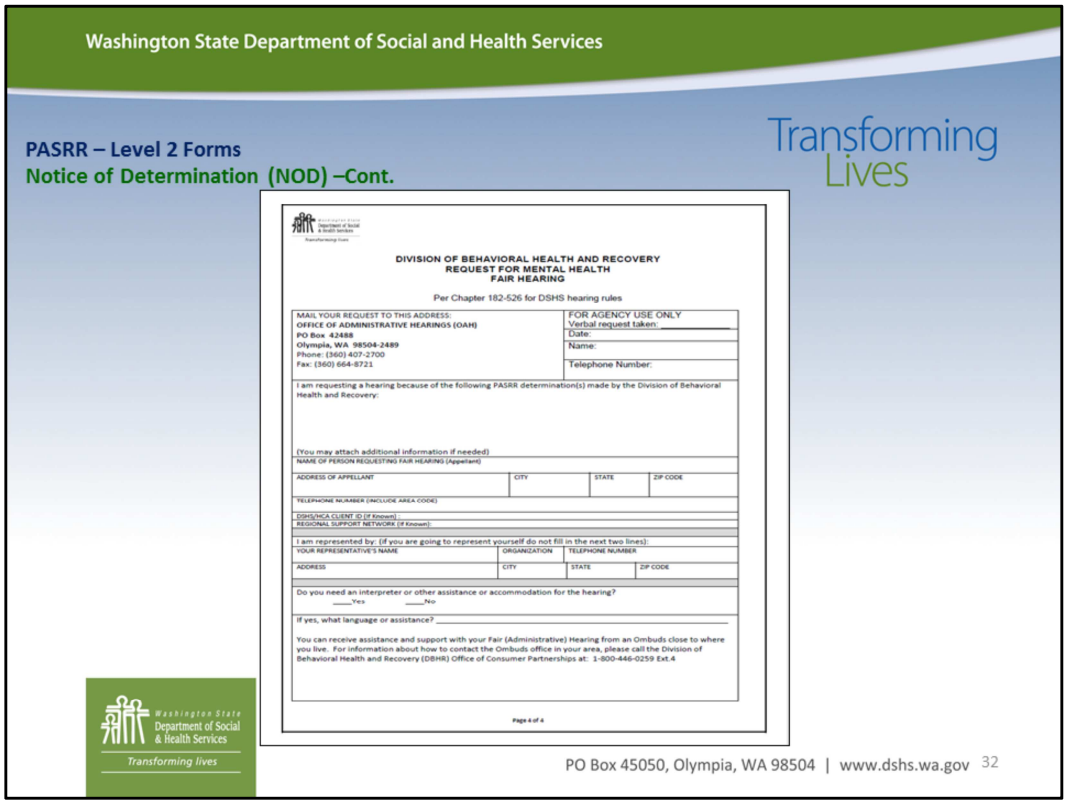
Gave instructions to hospital social worker to include in dc packet to SNF



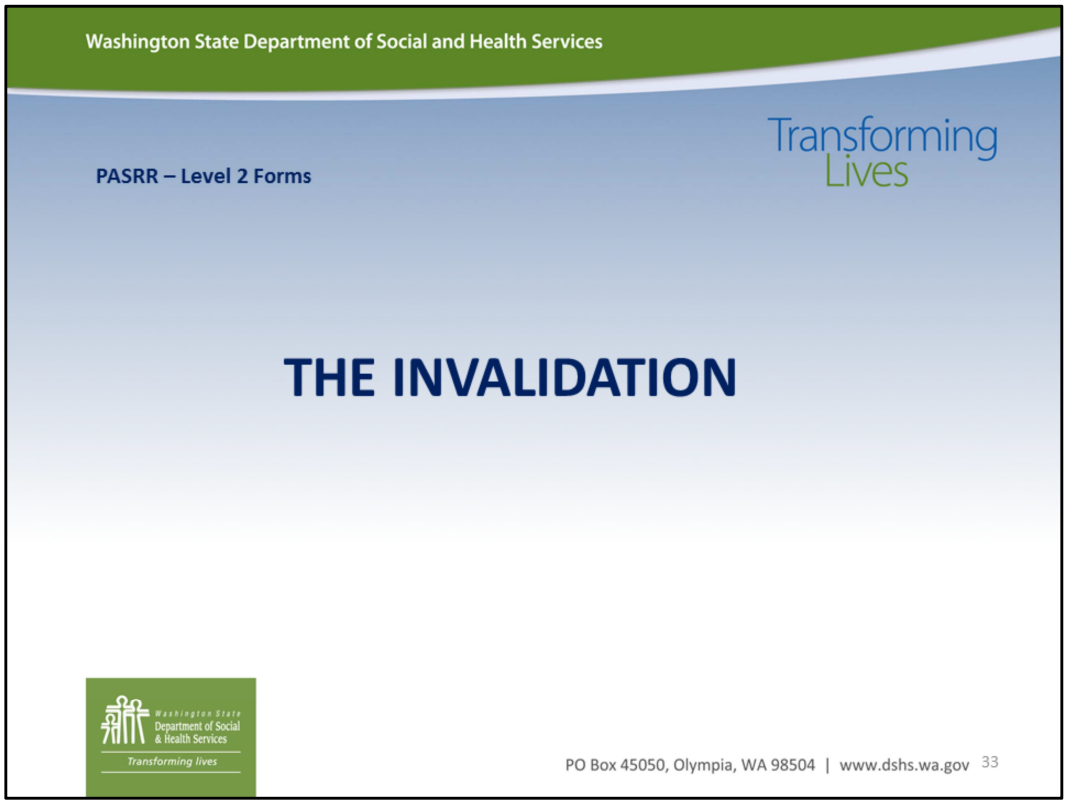

The information above is required to have in the NOD
Reference of authority – WAC etc.
Appeal rights for the individual are now listed along with options of other types of community residential settings




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.




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.


**DATE BOXES**

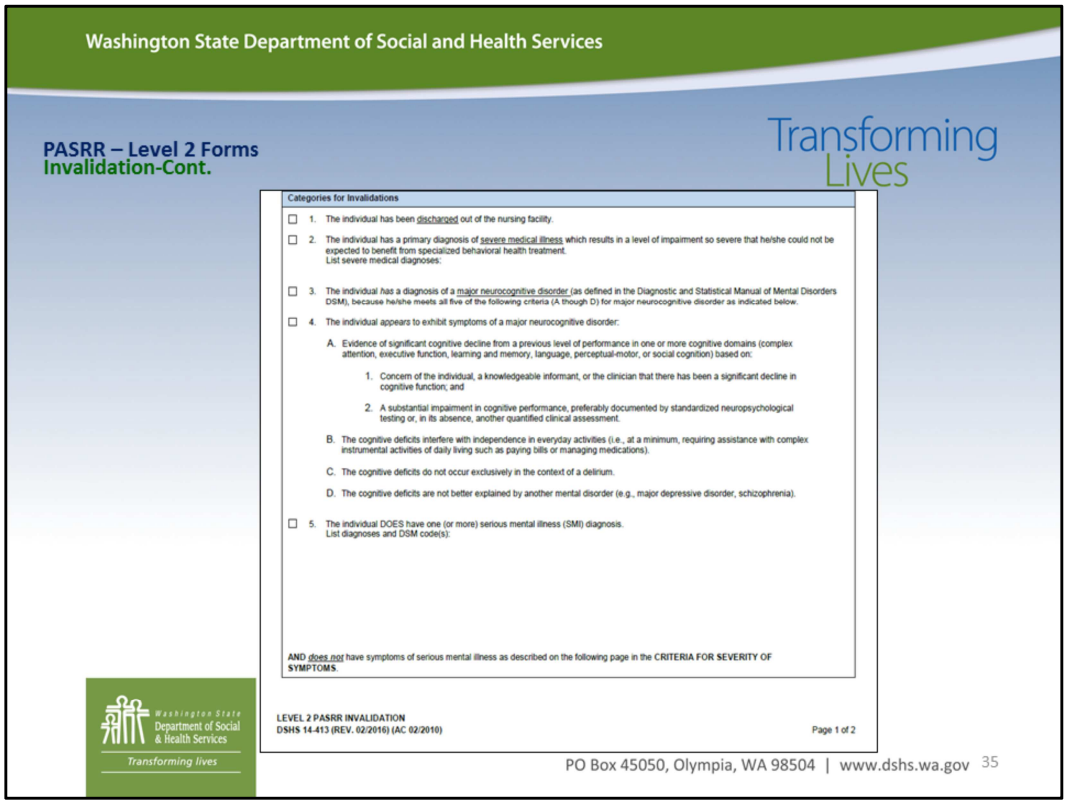
Date of Referral - Write/type in the date the referral was made to contractor.
Date of Invalidation - Write/type in the date the evaluation was completed or attempted.
Date of Birth - Write/type in the date of birth of the individual.

**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**

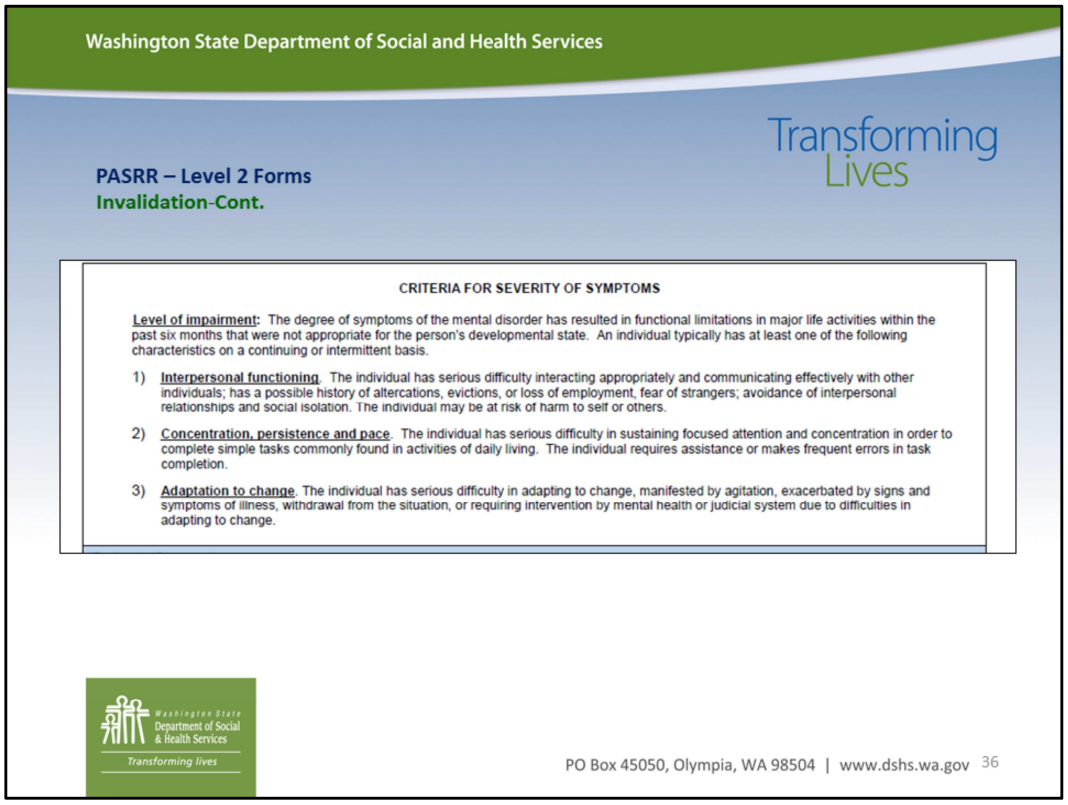
If the individual is currently in a nursing facility, check the "Current nursing facility resident" box and
provide the name, and complete address of the facility.
Check the Preadmission box if the individual has not yet been placed in a Nursing Facility. Inform
discharge staff to include the Invalidation in the discharge packet of information sent to the nursing
facility.




Check ***at least one*** category of invalidation that disqualifies the individual for a Level 2 Initial
Psychiatric Evaluation. Invalidations **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

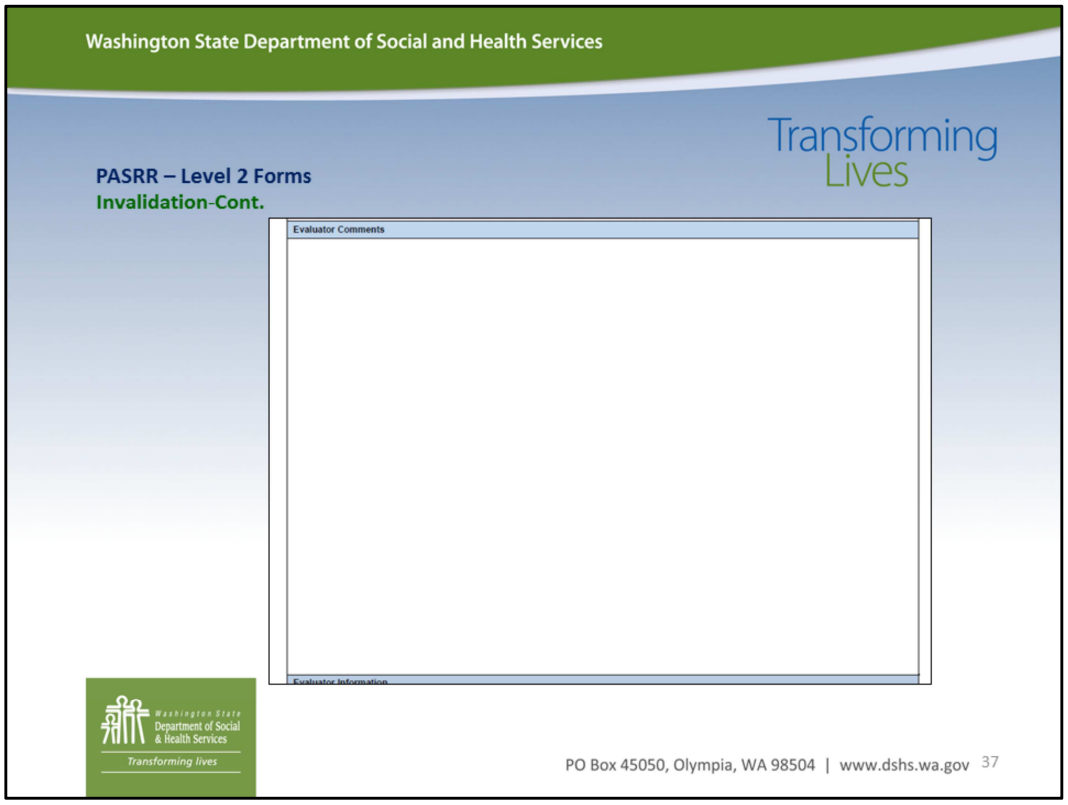



**CRITERIA FOR SEVERITY OF SYMPTOMS:**

**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

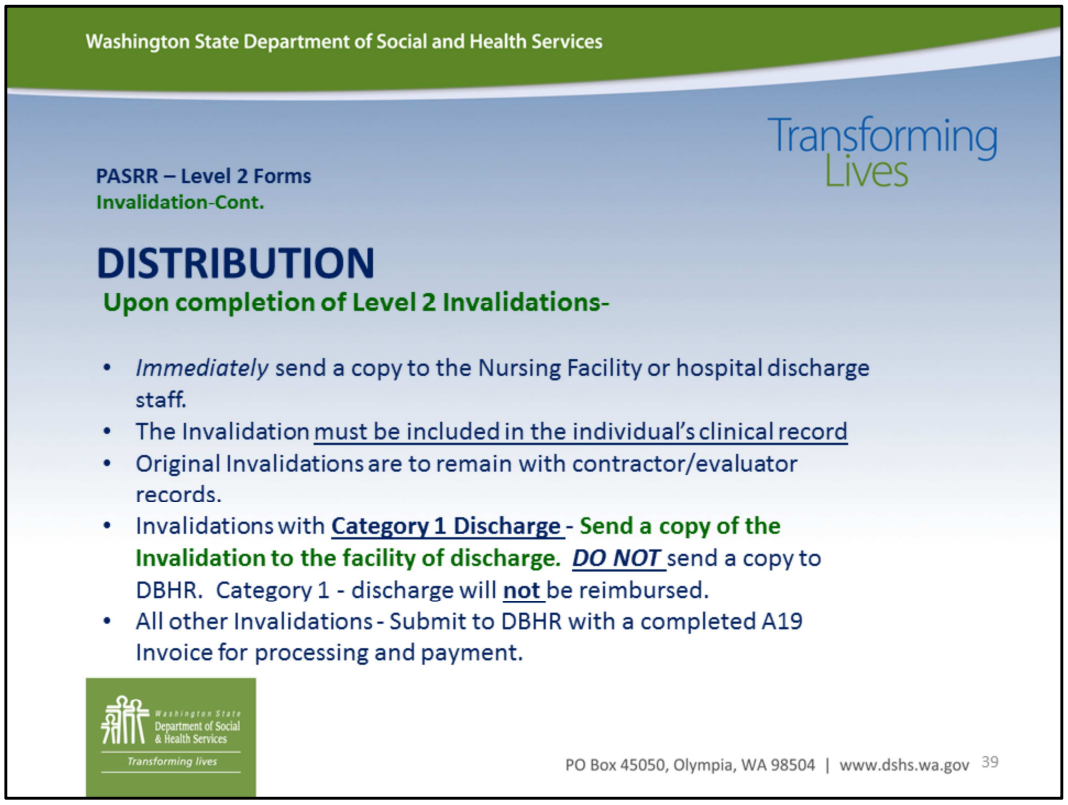



Evaluator Comments:

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.


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

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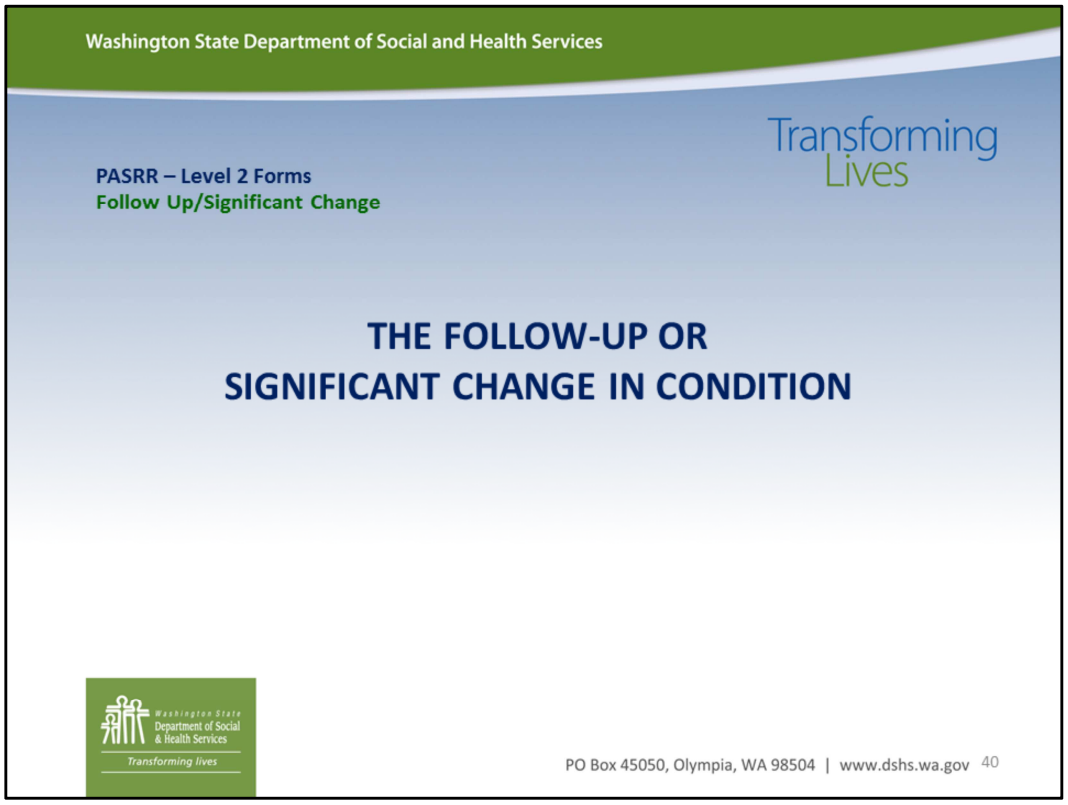
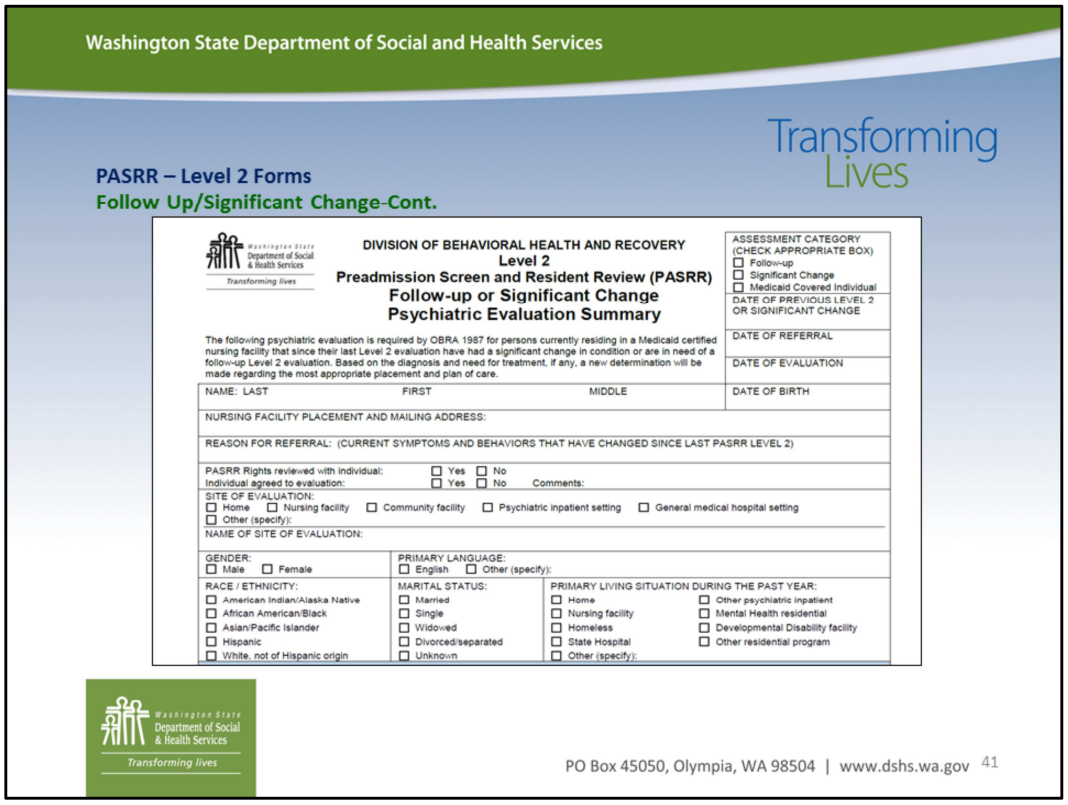



This psychiatric evaluation is intended to be filled out when individual's currently residing in a Medicaid certified nursing facility that since their last Level 2 evaluation have had a significant change in condition or are in need of a follow-up Level 2 evaluation. Based on the diagnosis and need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




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**

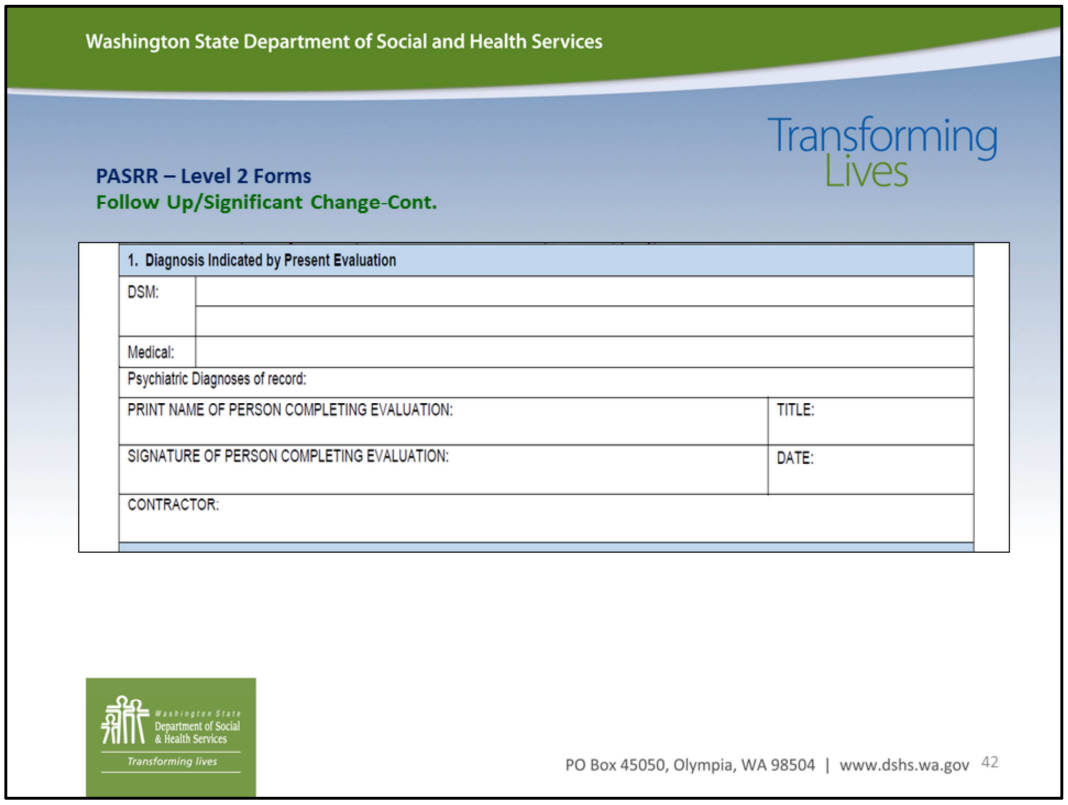
Check appropriate box.

**MARITAL STATUS**

Check appropriate box.

**PRIMARY LIVING SITUATION DURING THE PAST YEAR**

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




**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.

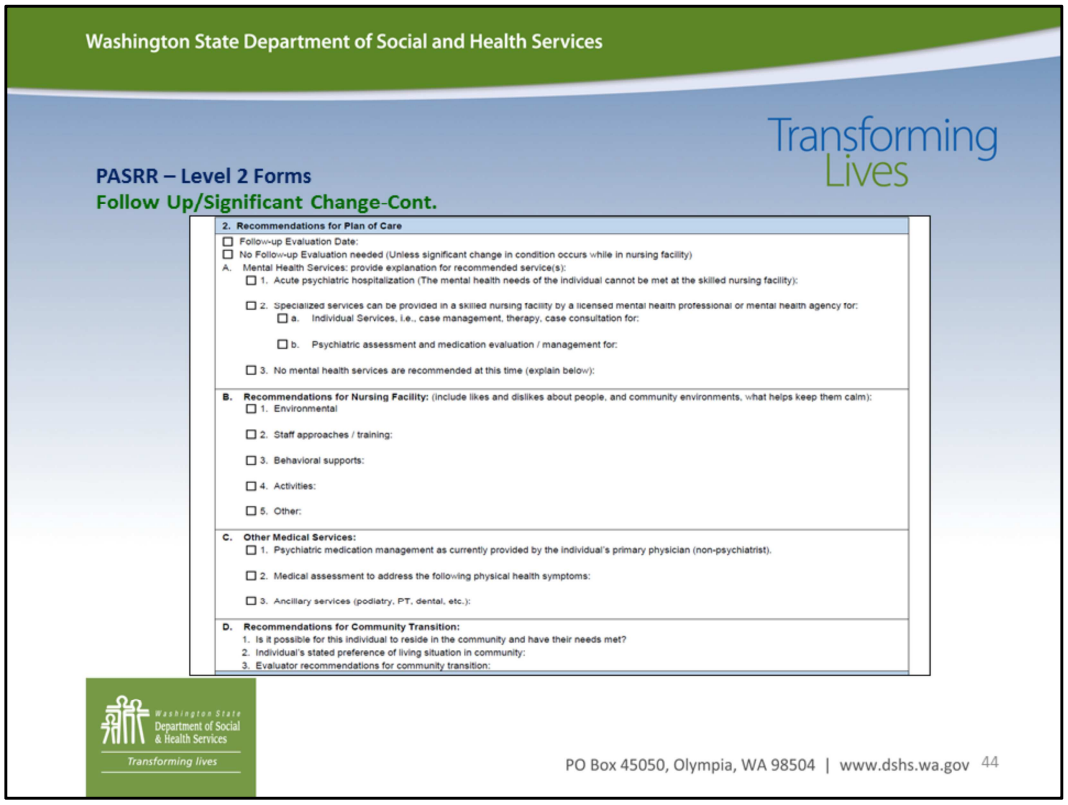

Write recommendations or comments related to the completed evaluation here. ***To be completed only by the reviewing psychiatrist.*** This is the portion is intended for the SNF staff and is to be reviewed by the SNF staff for implementation of any identified specialized services for incorporation into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




**<u>Follow-up evaluation date</u>**

**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).**

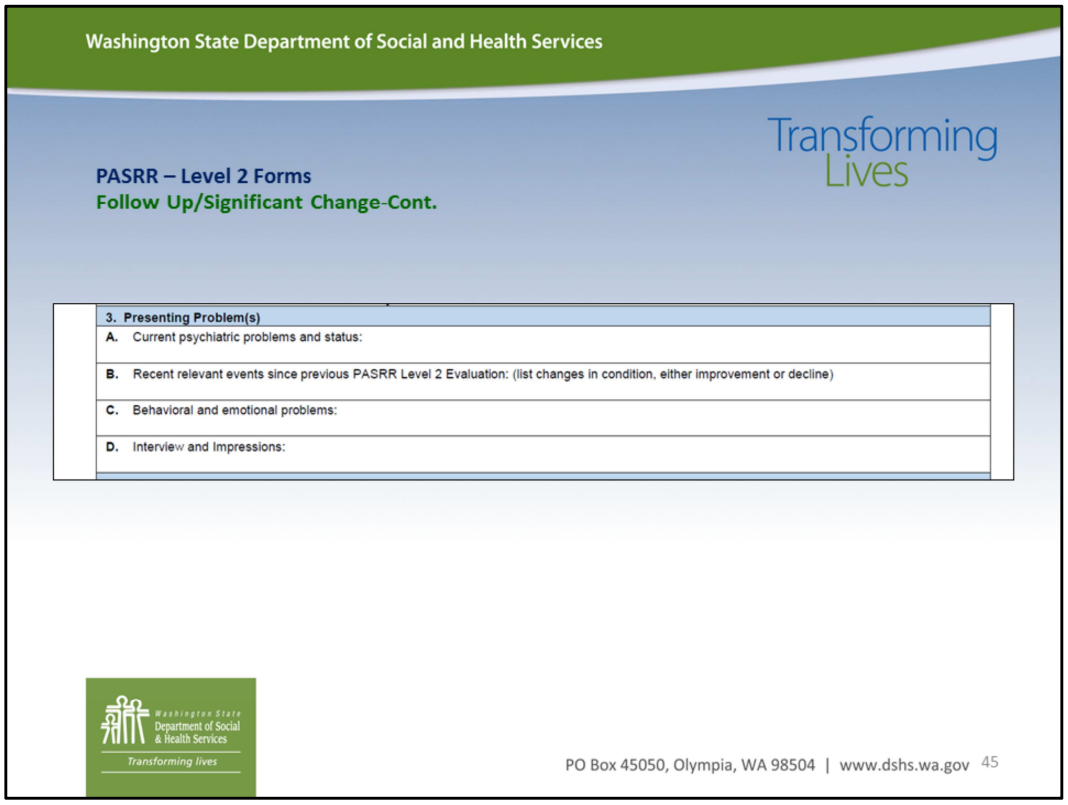
Write your recommendations in a manner that is appropriate for all levels of nursing facility staff. <u>Be descriptive</u>. Ask **"person centered"** questions that include likes and dislikes about people, and community environments, and what helps to keep them calm. Recommendations ***<u>must</u>***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

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

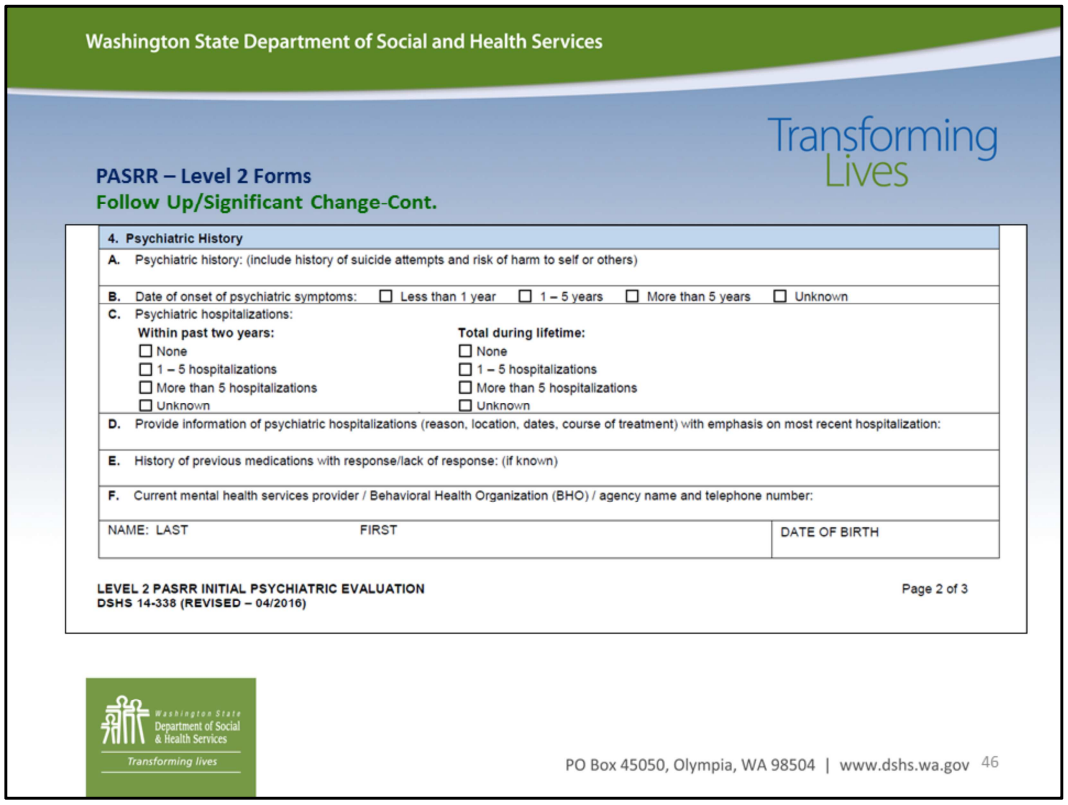
1. Note any psychiatric medication management currently prescribed.
2. Note any physical health symptoms that may impact their psychiatric condition.
3. Note any ancillary services that will benefit the individual during their nursing facility stay.

**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.




**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.




**A.** List all psychiatric history. Include inpatient treatment, outpatient treatment, any suicide attempts, or risk of harm to self or others.

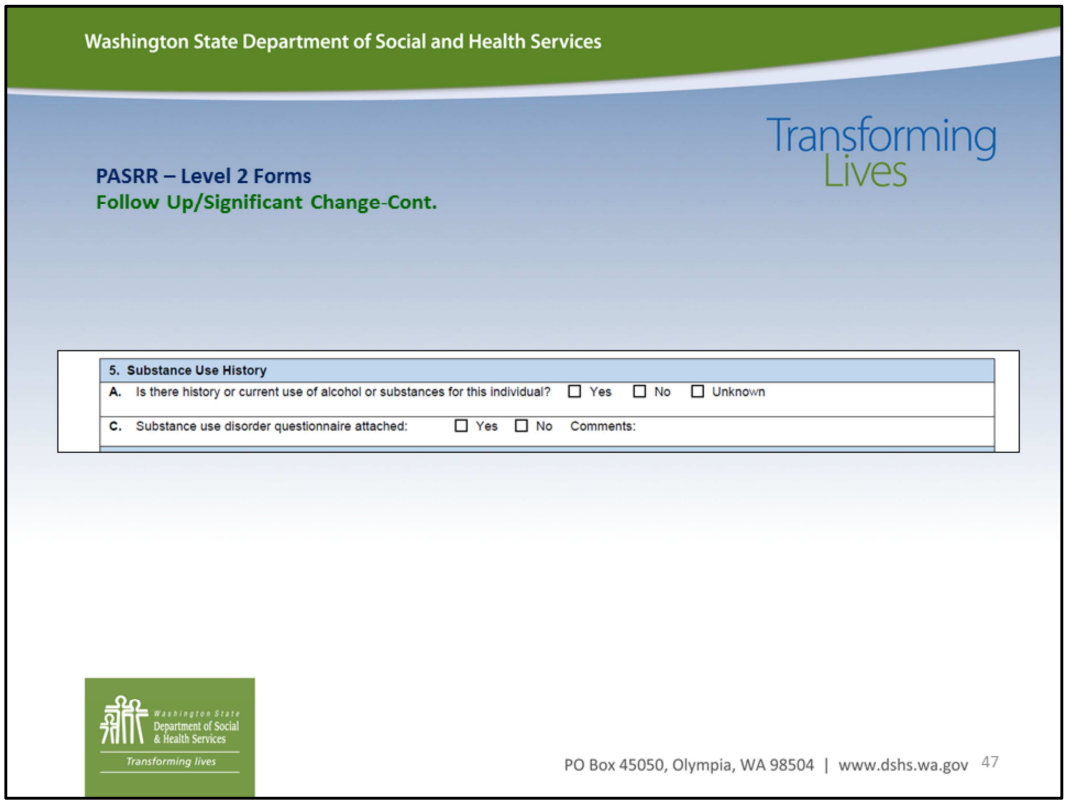
**B.** Onset of Psychiatric Symptoms - Check appropriate box

**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.

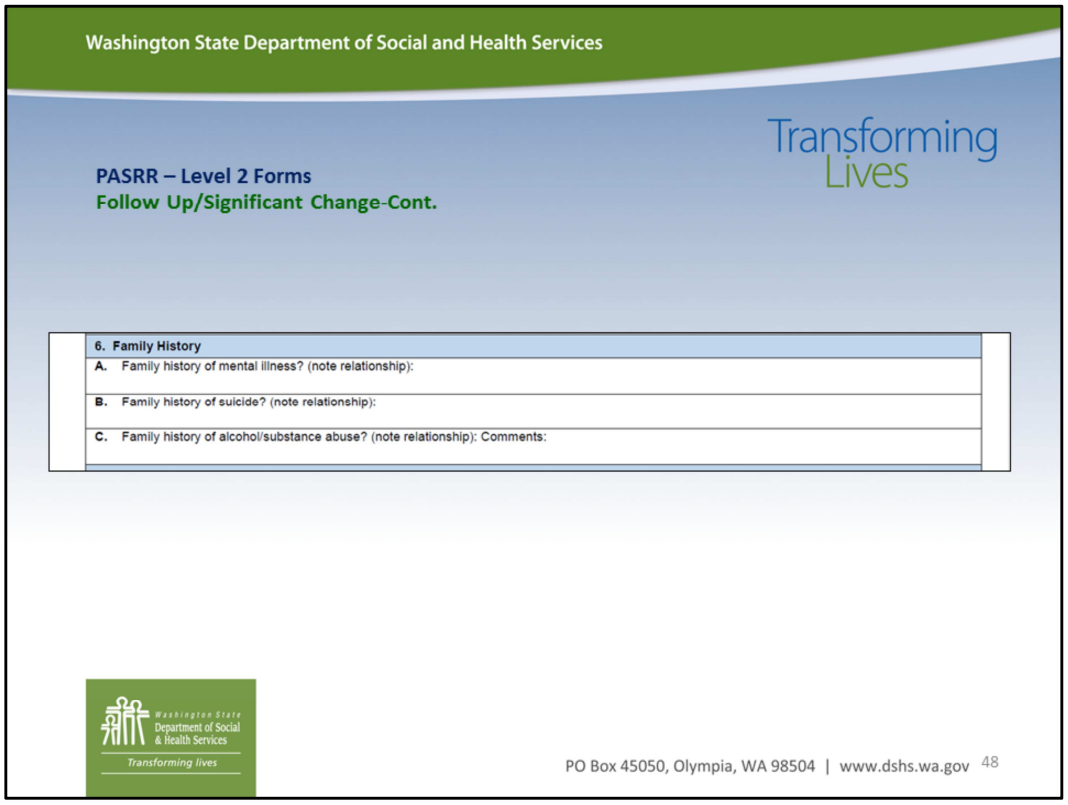
**F.** Current MH services-List current mental health provider if known and Behavioral Health Organization.



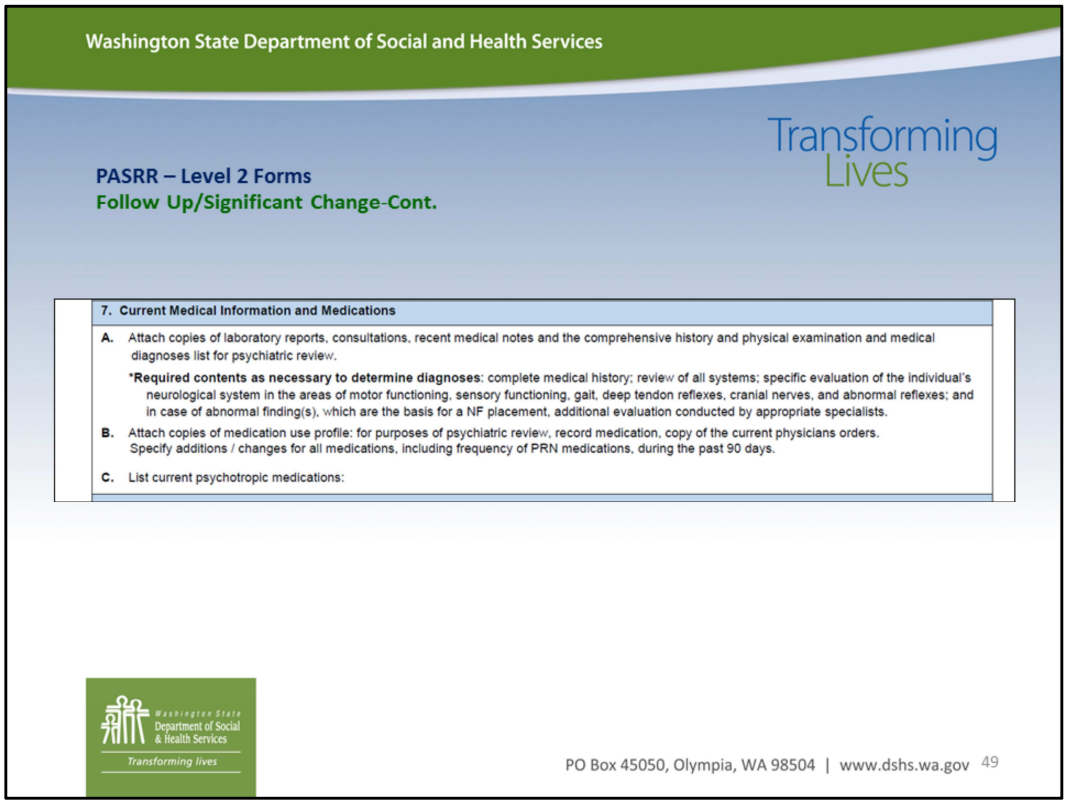

**A.** Is there a history or current use of substance or alcohol for this individual? Check appropriate box.

**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)**



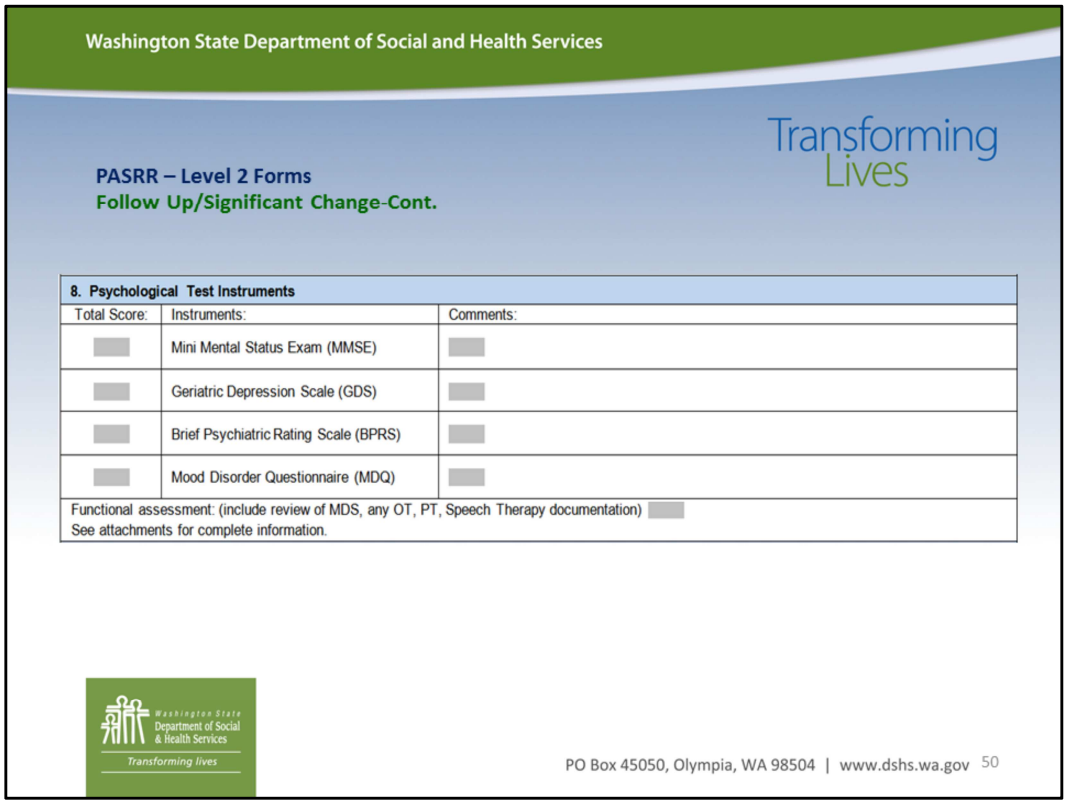

**A.** Is there a family history of mental illness for the individual? If yes, note relationship.
**B.** Is there a family history of suicide for the individual? If yes, note relationship.
**C.** Is there a family history of substance use for the individual? If yes, note relationship.




**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.**

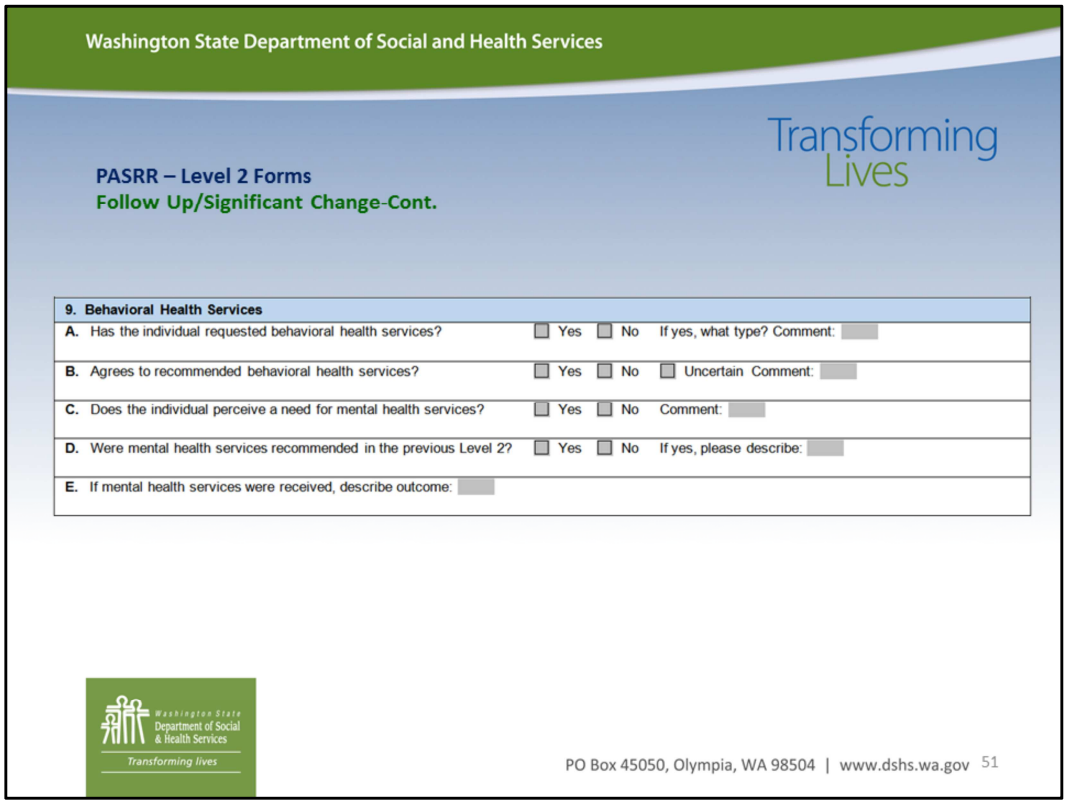



**Testing Instruments**

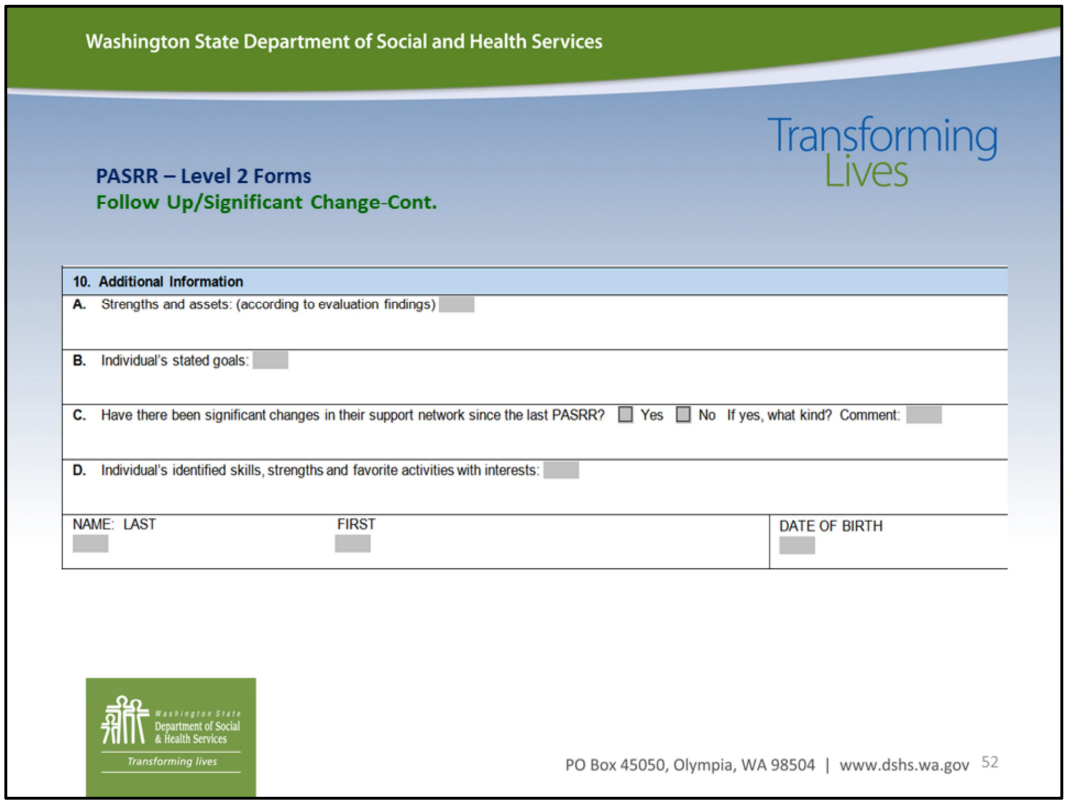
Complete all appropriate tests as needed documenting score and particular findings in the comment section. If the test is not preformed or does not apply write N/A in score box for each test.

**Functional assessment**

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




**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.

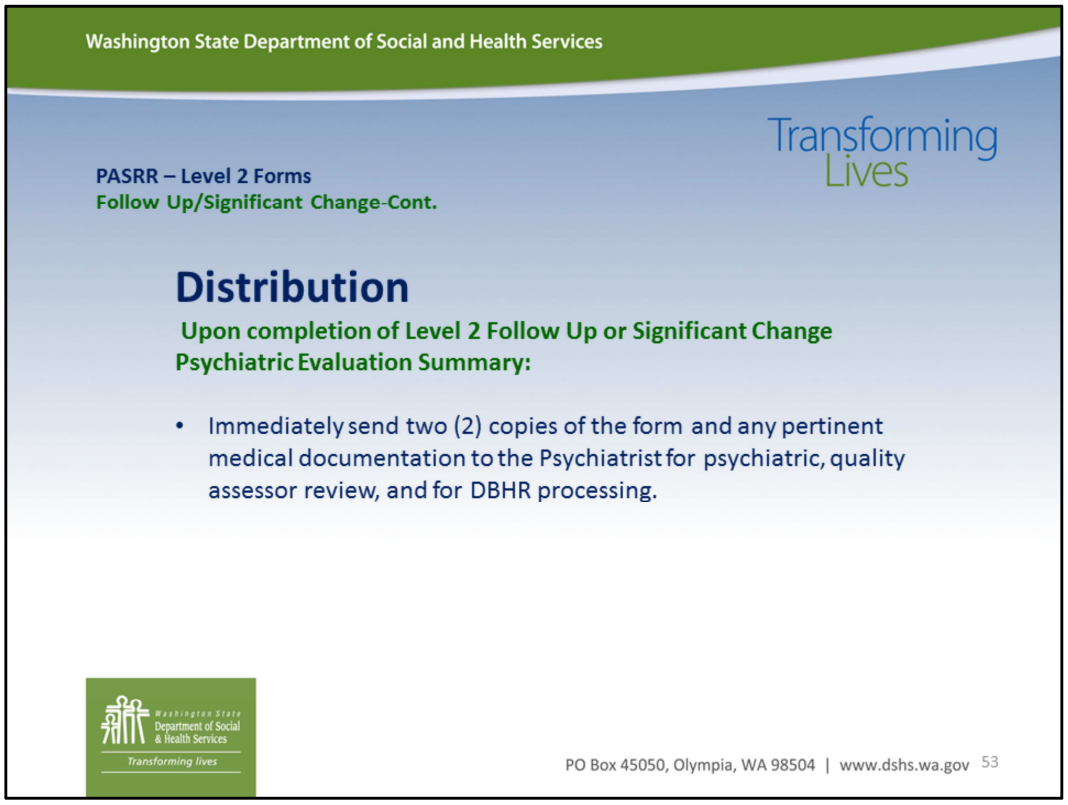



**A.** List the individual's strengths and assets according to this assessment and input from others.

**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.

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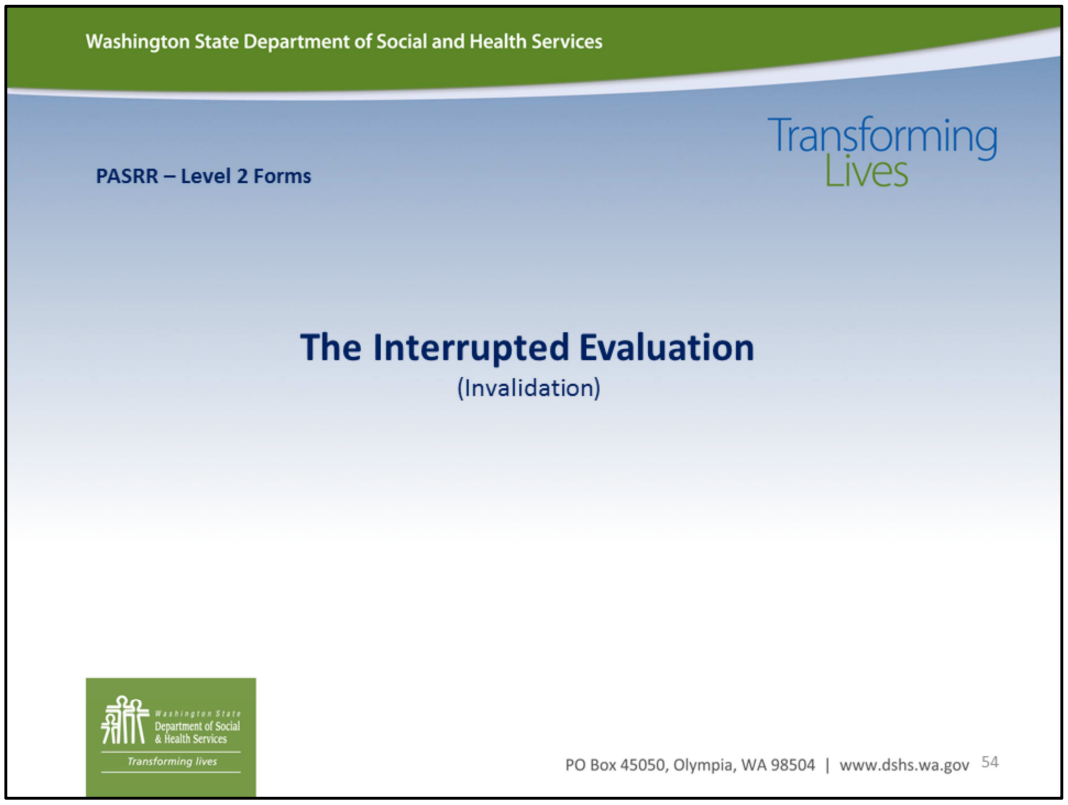
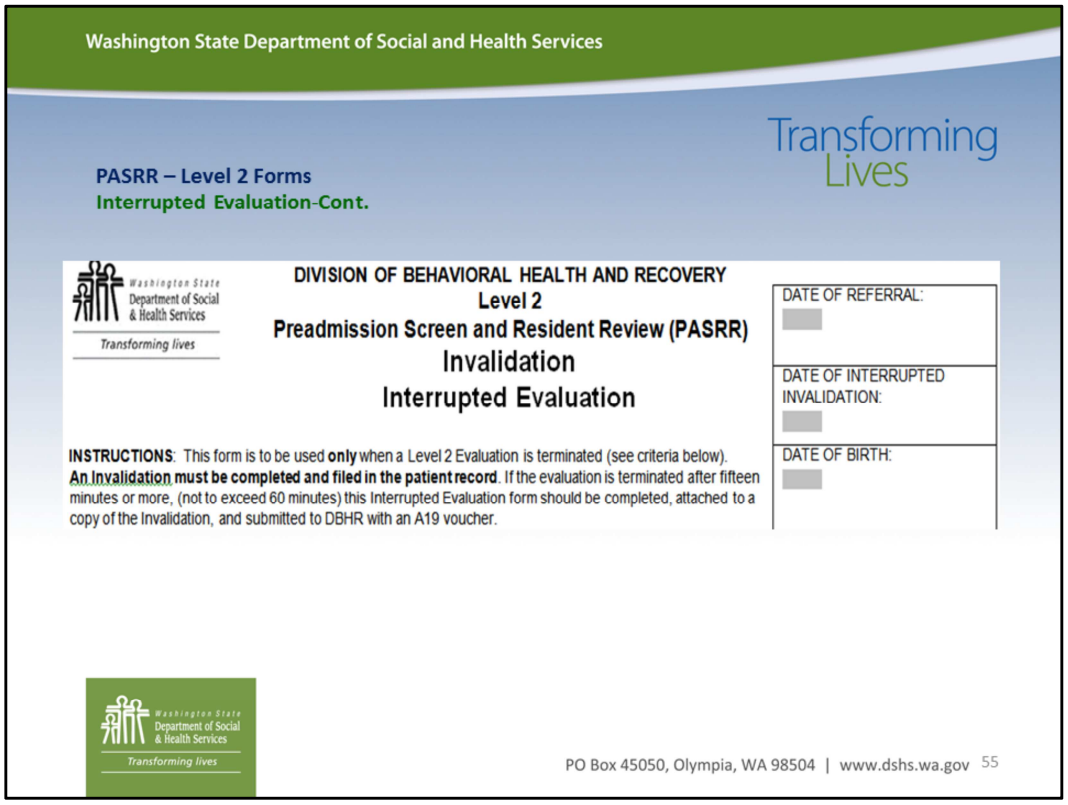
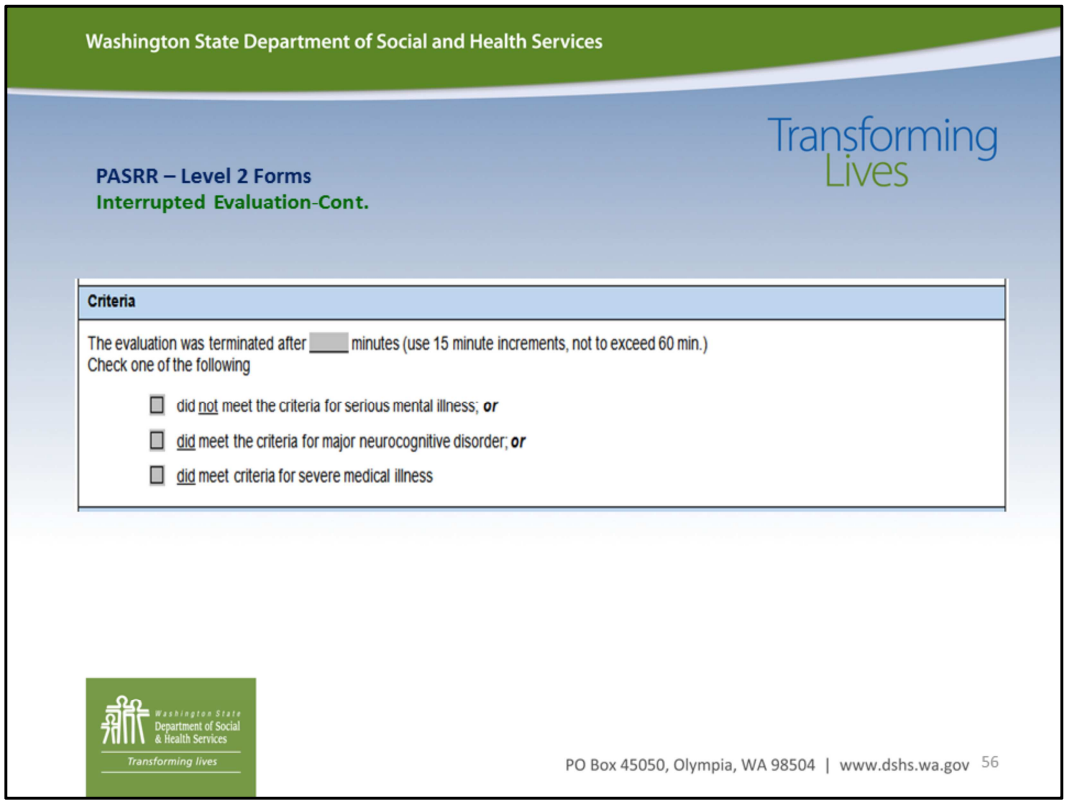



This form is to be used **only** when a Level 2 Evaluation is terminated.
The invalidation must be sent to the SNF for incorporation into the individual's clinical record.

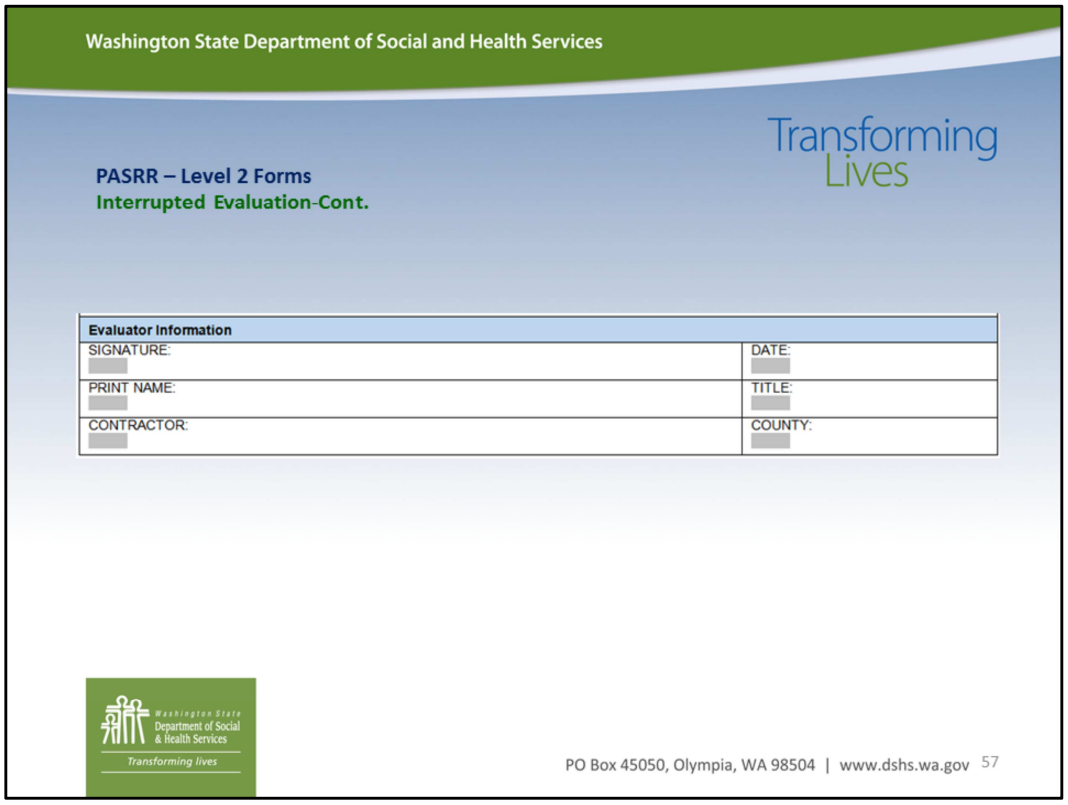



Type or write in the Date of Referral was made
Type or write in the Date of the Interrupted Invalidation
Type or write in the Individual's date of birth

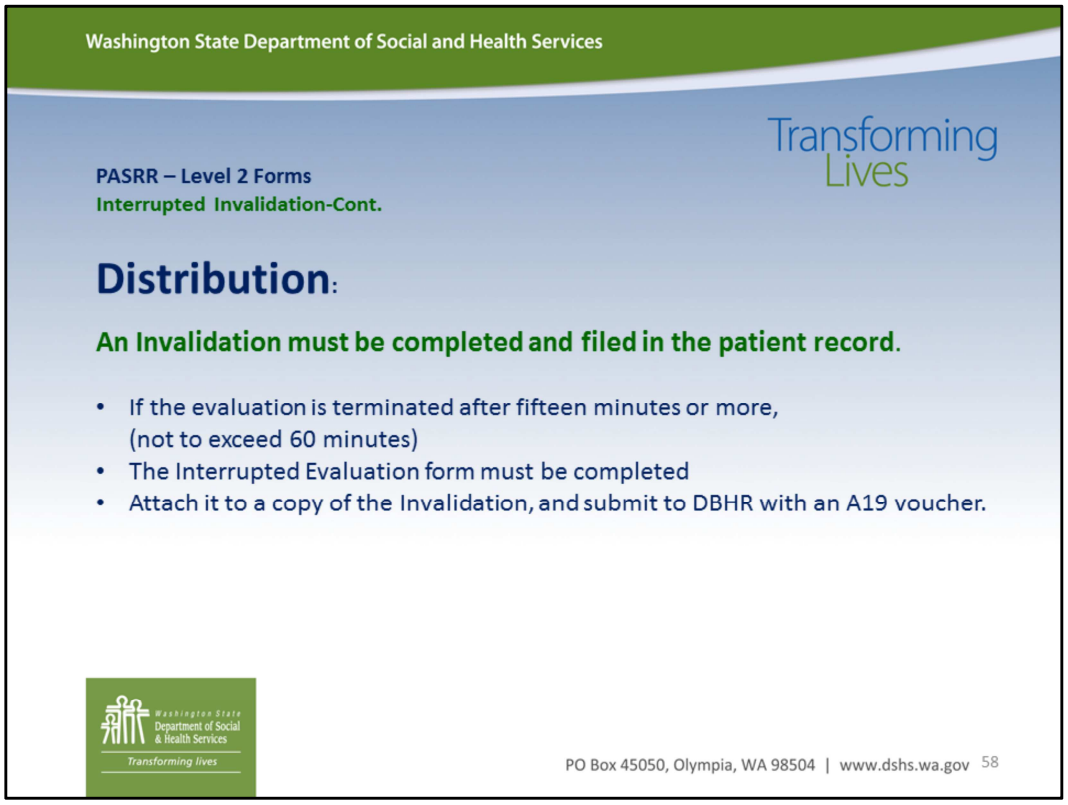



After beginning the Evaluation and upon interview, your findings reveal that one of the criteria listed on this slide applies,
Write or type in how many 15 minute increments were completed before terminating the interview.
***PLEASE NOTE***
The Interrupted Invalidation is **not indented to exceed 60 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:




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

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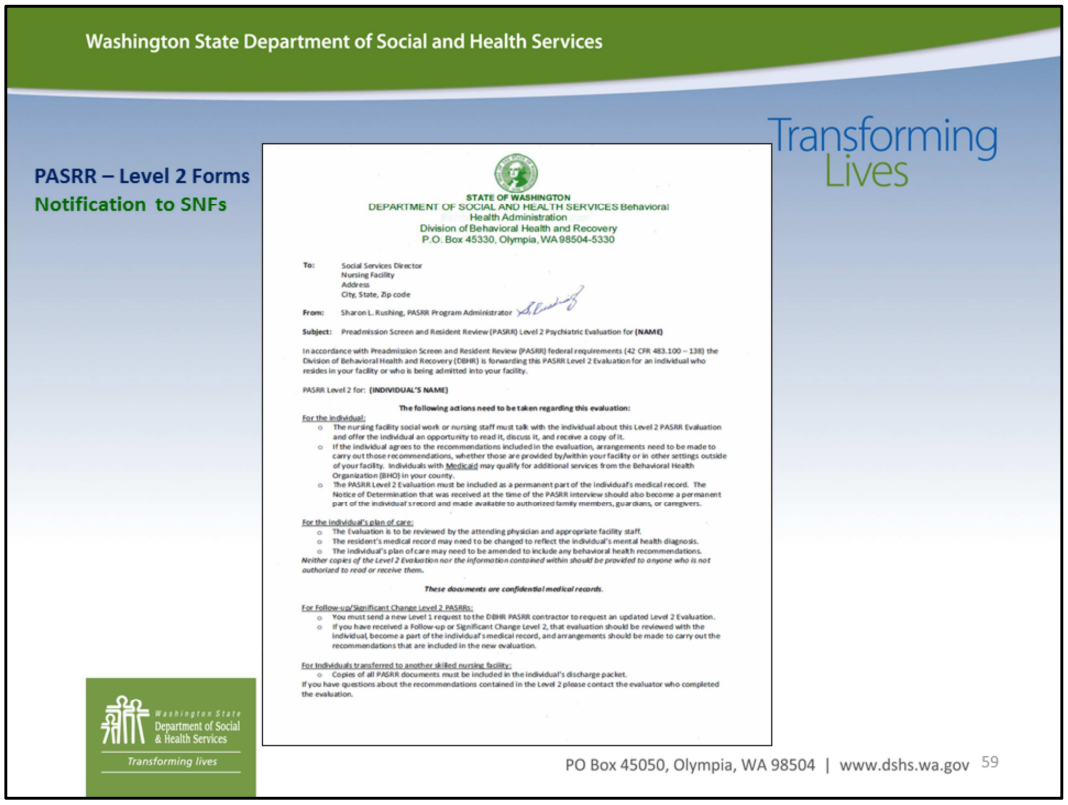
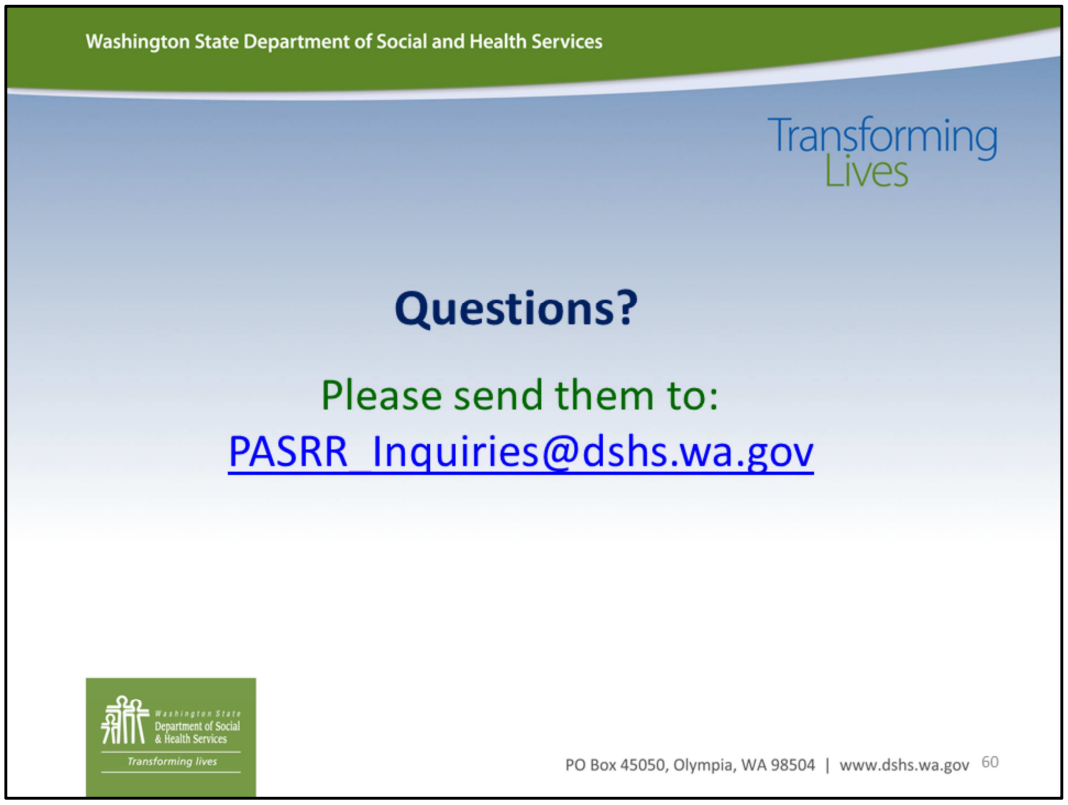



What happens to all of your completed Level 2 Evaluations?

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.




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.