Effective Practices in PASRR Evaluation Reports for Persons with Mental Illness

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Summary of session

- Brief background
- Overview of CMS requirements for evaluation report
- Discussion of evaluation report to support determinations and care planning
- Review of model template developed by NAPP
- Discussion/issues in application

CMS requirements for PASRR Evaluation Report

- Mental health/mental retardation evaluators must complete it
- Must be written in a manner that assists NFs to plan care
- Must be interpreted and explained to the individual and where applicable the legal representative
- Must be sent to:
  - Individual and their legal representative
  - State mental health/mental retardation authority
  - Admitting nursing facility
  - Attending physician
  - Discharging hospital
  - Filed in current medical records

CMS required contents of the Evaluation Report

- Summary of medical and social history (including positive traits/developmental strengths, weaknesses and/or needs)
- Findings correspond to the person's current functional status as documented in medical and social history records
- Specific NF services, specialized services and other services the person needs
  - Distinguish NF-provided services from Specialized services provided by state
- Evidence to support conclusions regarding admission
- Name, title of evaluators; date of administration

Introduction to the PASRR Evaluation Reports for Person Centered Outcomes

Summary of Presentation

Review Potential Functions of the PASRR Evaluation Reports

- State & provider benefits
- Individual benefits

Review some State Differences in the PASRR Evaluation Report

- Features of different evaluation reports
- Review of State forms: AL, CN, FL, GA, NE, NV TN, VA
- Differences in service recommendations for NF, MH, IDD services > Determination of NF, NF Specialized Rehabilitative Services, Specialized Services

Summary of Presentation (cont.)

Review Examples of Service Topic Areas & Services Recommendations for Care Planning

- Individualized strength based care planning
- Services and service coordination
- Integration with medical care needs
- Health education and prevention
- Supportive relationships, appropriate activities, and rehabilitation
- Targeted or behavioral care planning
- Risk management (safety for self and others, self management & pre-crisis planning, environmental management, risk of eviction)

What is the PASRR Evaluation Report?

- Minimum Data Report Requirements?
- Integrated Assessment Summary?
- Evaluation of Assessment Findings?
- Preliminary Recommendations for Service Determinations?
- Combination?

Evaluation Report Outcome Goal:

- Appropriate care in discharged/NF settings

Evaluation Report Process:

- A communication and directive function
- A classifying function for service needs
- Presents reasons why an individual should go one direction or another
- Contains detailed information to support/explain why NF placement is/is not appropriate

Features of the PASRR Evaluation Report

- Based on assessment by qualified professionals (e.g. trained to interview & assess specific needs; skilled in gathering information from individuals, support networks, providers and records; and trained in transferring information into a written report)
- Supports determinations for appropriate services and placement
- Defines care needs for optimal health
- Provides pertinent information for care planning and survey monitoring

Function of the Evaluation Report

- Provides data for LOC determinations for individuals with MI & IDD (§483.132 and, as appropriate, §§483.134 and 483.136)
- Provides data for service determinations (Basic NF Services, NF Specialized Rehabilitative Services, and Specialized Services)
- Provides data for determination of appropriate placement
- Potentially available for those not admitted to NF or discharged, possibly as result of PASRR, to other treatment settings

Evaluation Report and NF Functions

Enriches Hospital Discharge Planning; NF Admission Screening and Care Planning Process

- Supports coordination between NF's resident assessment & the PASRR process (§483.106(a)).
- Could make recommendations for basis of NF plan of care until completion of NF Resident Assessment
- Provides data for use in NF Resident Assessment
- Available in NF record for ongoing care planning

Enriches NF Care Planning Process

- Appropriate for evaluator(s) to review the NF's plan of care
  - could comment on plan of care
  - ratify care plan
  - make suggestions for changes or additions
- Available to demonstrate status of residents for surveyor’s monitoring of care

Evaluation Report & Potential for Great Impact on Individual's Options for Future Care

- Supports disabled populations when extra care must be given to allow individuals with MI & IDD to exercise their rights.
- Can provide mechanism for individuals to understand the basis for determinations to recognize if an appeal should be submitted
- Available to individual to assist with gaining advice from an advocate
- Can provide process for the individual or legal representative to be informed both verbally and in writing

Options for Care: How does other Programs for NF Residents/Applicants Integrate with the Level II Process for Persons with MI & IDD?

Goal: Emphasize recovery, medical and psychiatric rehabilitation & potential for home & community-based services

- Medicaid HCBS Waiver and other Waiver
- Nursing Home Diversion & Transition Programs
- Other Community Services

PASRR Evaluation Reports

What is in the PASRR Evaluation Report?

Components of Level II Requirements:
Minimum Data Requirements

- Medical history
- Social history
- Positive traits or developmental strengths of the evaluated individual
- Weaknesses or developmental needs of the evaluated individual
- Services, treatment, and other recommendations for care planning
- Other (See 483.128(i))

State Differences in the PASRR Evaluation Report

- What is in the PASRR Evaluation Report?
- Where does it fit into the PASRR Process?
- What does in look like?
- Who completes it?
- What is the format?
- How is it transmitted?
- What does it accomplish?
- How well does it function?

Where does the Evaluation Report fit into the PASRR Process?

Component of the Level II Process:

- Stand-alone document?
- Integrated with other Level II assessment requirements?
- Integrated with PASRR level II determination documents?
- Other?

What are State Differences in PASRR Evaluation Report ?

What is the style?

- Descriptive style
- Categorical data
- Check list
- Level of Detail

Who completes it?

- Level II evaluator(s)
- State Level II determination personnel
- Completed by single or multiple professionals

State Differences in PASRR Evaluation Report

What is the format? How is it transmitted?

- Electronic evaluation report
- Paper format
- Web based evaluation report
- Other ?

How do we look at State Differences in PASRR Evaluation Reports?

Are there common key components in any of the required areas?

- Medical history
- Social history
- Positive traits or developmental strengths of the evaluated individual
- Weaknesses or developmental needs of the evaluated individual
- Other

How is there a Person Centered /Strength Based Emphasis in the Evaluation Report?

- Identifies unique strengths, abilities, and preferences
- Provides communication with the individual
- Includes family, responsible party, natural supports, providers, & advocates, as appropriate
- Identifies unique needs-especially needs around discharge barriers
- Identifies challenges and potential solutions

Strength Based: Documentation of Strengths & Limitations/Weakness

- Community involvement
- Unique coping strategies
- Communication
- Goal directed
- Understanding of Illness/Insight
- Health behaviors
- Resilience/flexibility
- Resourcefulness
- Social supports
- Social competence
- Unique personal characteristics
- Ability to work with supports/engagement
- Responsiveness
- Confidence & motivation
- Preferences & enjoyments
- Problem solving abilities
- Family involvement

Evaluation Report: Opportunities for Person Directed Care Planning

- Opportunity for active involvement of the NF applicant/resident
- Considers meaningful lifestyle and values
- Incorporates health beliefs, individual's learning process, and skill level
- Addresses spiritual & cultural needs
- Considers how the individual would like to deal with the situation
- Supports engagement in meaningful life activities
- Promotes personal growth & improvement/ maintenance of functioning

Person Centered: Identifying Justification for Needed Services

Abilities, skills, performance, and Impairments

- Activity level
- Age appropriate needs
- Behavioral status
- Cognitive ability
- Cultural diversity needs
- Medical acuity
- Sensory deficits
- Mobility issues
- Nutritional issues
- Natural supports-psychosocial status
- Social interaction

Person Centered: Identifying Justification for Needed Services

Observations & Coordinated Information from Individual, Health Care Providers, and Natural Supports (as appropriate)

- Demonstration of maladaptive behaviors
- Presence of skills/skill deficits
- Understanding of simple commands
- Ability to learn new skills
- Specialized training needs
- Ability to apply skills learned
- Change in status
  - Deterioration
  - Improvement
  - No change
- Treatment adherence issues

Does the Evaluation Report Provide Care Plan or Service Plan Recommendations: Is there always a difference?

- Basic NF Services and Care Planning
- NF Specialized Rehabilitative Services and Care Planning
- Specialized Services and Care Planning
  - Categories of Services
  - Specialized Habilitative/Rehabilitative Services
  - Individualized Care Recommendations

Service Plan Recommendations

Is there common language to categorize services?

- Is it a type of service? Intensity of service?
- Location for service delivery?
- Classification for provider responsibility & payment?
  - NF MH & IDD services
  - NF specialized rehabilitative services (e.g. IDD, MH, SA Services)
  - Professional MH, IDD and SA services
  - Specialized services

Care Plan Recommendations

Are there common key topic areas to describe recommendations for care planning ?

- Individualized strength based care planning
- Services and Service coordination
- Integration with medical care needs
- Health education and prevention
- Supportive relationships, appropriate activities, and rehabilitation
- Targeted or behavioral care planning
- Risk management (environmental, risk of eviction, safety for self and others,
- Self directed-risk management (pre-crisis planning, early warning signs of stress, stress reduction & coping strategies, plan to reduce risk, engaging natural supports, relaxing and meaningful activity, monitoring & evaluation of action plans, signs of changing needs & care plan revision)

Are there key areas in care plan recommendations targeting appropriate placement?

- Age/developmentally appropriate services
- Monitor for appropriate placement
- Support for NF transition
- Discharge planning
- Other

Habilitative, Restorative, and Long Term Services

- Restorative nursing
- OT & PT services
- Nutrition services
- Visual/Hearing aids
- Assistive devises
- Medication management
- Crisis intervention
- Monitoring & advocacy
- Sensory stimulation
- Communication assistance
- Self care assistance
- Services for adjustment needs
- Socialization activities
- Psychosocial rehabilitation

Targeting Skill Development

- Social skill development
- Communication skills
- Personal care management skills
- Nutritional management skills
- Medication self management skills
- Problem solving/crisis management skills
- Community skills
- Task learning skills
- Self help skills
- Behavioral skills
- Self advocacy skills
- Resource utilization skills
- Environmental management skills

State Specific: Basic NF Services, NF Specialized Rehabilitative Services, or Specialized Services

- Outpatient psychiatric counseling
- Psychiatric consultation
- Diagnostic services
- Psychological testing
- Decision making assistance
- Self-management training
- Consultation and intervention training for behavior management
- Stress management plan/Pre-crisis plan
- Behavioral health advanced directive plan
- Vocational services

State Specific: Targeted or Specialized Services

- Targeted case management exploring community options
- Support coordination
- Specialized health education & training
- Day treatment
- Partial hospitalization
- Developmental skills training
- Age specific services
- Diagnostic specific services
- Age appropriate activities/habilitation
- Specialized /Targeted assessments & care planning
- Support group for recovery from SA

What is the Differences in a Abbreviated Written Report for Categorical Determinations?

- Reduced documentation requirements for categorical advanced group determinations (e.g. convalescent care, dementia & IDD or need for particular service (see § 483.128(h))
- Clearly indicates NF admission/residency is normally needed
- Or specialized services is not normally needed
- Category can be developed by State MH or IDD Authorities and incorporated into State Plan

How Can we Learn More on Evaluation Reports From Other States?

- State PASRR web sites
- State form documents
- State practices and guidelines
- Procedure guidelines for PASRR evaluators
- Procedure guidelines for determination of service needs
- Networking/ Conference calls
- Ideas? Next steps?

Discussion

Model Evaluation Report

PASRR Evaluation Summary

Determination related to Mental Illness

Client Name:	DOB:
	Gender:
Location of assessment:	SS #
Date of assessment:	Medicaid #":

Model Evaluation Report /MI (cont'd)

1.Disability status as indicated by PASRR assessment

□ The individual does not have a serious mental illness

□ The individual has a serious mental illness and requires specialized services in an acute setting

□ The individual has a serious mental illness but meets criteria for nursing home admission

<u>Please identify any additional supports the individual may need within the nursing facility</u>

___ Psychosocial rehabilitation
___ Behavior management
___ Individual/group therapy
___ Structured day activities
___ Psychiatric consultation
___ Psychotropic medications
___ Medication education for self-administration
___ Medication management

Other:

_____

_____

_____

Model Evaluation Report /MI(cont'd)

2. Recent psychiatric history (add separate page if needed):

3. Psychiatric summary:

Axis I Primary: _____ Axis II Primary: _____
Axis I Secondary: _____ Axis II Secondary _____
Axis I Tertiary: _____ Axis II Tertiary _____

4. Medical/Social History (including individual strengths and weaknesses; add page if needed)**:**

5. Primary reason for seeking nursing facility:

Model Evaluation Report /MI(cont'd)

Client Name: _____

6. Living Arrangement prior to nursing facility _____
_____

7. Can the individual return to previous living arrangement if discharged? (If not, why not?)
___ Yes ___ No (explain):_____
_____

8. Recommended supports if individual wishes to return to community:

___ Medication monitoring/education
___ Individual therapy/counseling
___ Training in community living skills
___ Care management/service coordination
___ Referral to state mental health agency
___ Medication administration
___ Family therapy
___ Family involvement
___ Vocational services
___ Guardian/conservator/POA
___ Other services (specify): _____
_____
_____
_____

Model Evaluation Report/MI (cont'd)

9. Evaluation completed by:

Evaluator _____ _____

(name, title, credentials) (Date)

10. Admission determination

□ Approved for admission/continued stay in a nursing facility with reevaluation at ___ months

□ Approved for admission/continued stay in a nursing facility on a long-term basis

□ Not approved for admission to a nursing facility

11. Reviewer comments/rationale for decision:

_____

_____

_____

12. Determination completed by:

Reviewer: _____ _____

(name, title, credentials) (Date)

Distribution (please check and distribute to all that are applicable)

__ **Individual** __ **Attending physician/primary care practitioner**

__ **Discharging hospital** __ **Legal representative**

__ **Admitting nursing facility** __ **State Mental Health Authority**

__ **Other** _____

—Final Discussion—

Would this tool be useful in your state?

Would your state be interested in piloting?

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Thank you for participating!

Resources

Department of Health And Human Services, Health Care Financing Administration (HCFA). Monday, November 30, 1992. Federal Register , Medicare and Medicaid Programs; Preadmission Screening and Annual Resident Review
Final rule with comment period. Title 42. Vol. 57 No. 230 42 CFR Parts 405, 431, 433, and 483.

PASRR Self Assessment. Self-Evaluation for States. Preadmission Screening and Resident Review (PASRR) DRAFT — 12/13/2011

The Commission on Accreditation Commission (CARF) International. (2011). 2011 Behavioral Health Standards Manual. Tucson, Arizona: Commission on Accreditation of Rehabilitation Facilities, Inc. Available at www.carf.org

The Commission on Accreditation Commission (2003). CARF Assisted Living Standards Manual with Survey Preparation Questions July 1, 2003-June 30, 2004. Tucson, Arizona: The Commission on Accreditation of Rehabilitation Facilities, Inc.

The Joint Commission W-edition. July 1, 2011. The Joint Commission Resources. Available at https://e-edition.jcrinc.com

AL, CN, FL, GA, NE, NV TN, and VA STATE PASRR Forms