

PASRR: The Dementia Exclusion for Serious Mental Illness

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Webinar Objectives

- Clarify PASRR/Dementia MI basic relationship
- Review current concerns about practices related to Dementia/MI
- Clarify the responsibilities of Level I Screeners and Level II evaluators
- Identify primary confusion areas related to Dementia/MI
- Identify best practices for considering Dementia/MI
- Identify resources for training related to Dementia/MI

Dementia/MI: A CMS Perspective

“In the past, I think, CMS did not do a very good job of helping states interpret PASRR, and you were kind of left with the CFR, which gives you kind of a sense that there’s an algorithm. If this, then that. You know, gives you a compass of the rules so you’re complying with the federal requirement. In reality, what you need to be doing with PASRR is way more individualized and not a formula.

Almost no part of your PASRR process can just have a simple ‘if this, then that.’ So, and some of you are sick of me saying this, but any time you have a question like this, you should ask yourself, ‘what would help people?’” – Dan Timmel

Question 1

What is the overall intended relationship between dementia/neurocognitive disorder and PASRR?

Question 1: The CFR Guidance

- PASRR regulations permit Level II evaluations to be terminated if the Level II evaluator finds that individual has:
 - 1. “A primary diagnosis of dementia (including Alzheimer’s Disease or a related disorder)” (42 CFR 483.128(m)(2)(i)); or
 - 2. “A non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness, and does not have a diagnosis of MR (ID) or a related condition” (42 CFR 483.128(m)(2)(ii)).

Question 1: The CFR Intent

- In other words, the evaluation may be halted if the individual does not have MI/ID/RC, or
- Has—
 - (i) A only a primary diagnosis of dementia (including Alzheimer's Disease or a related disorder); or
 - (ii) A non-primary diagnosis of dementia without a primary diagnosis that is a serious mental illness, and does not have a diagnosis of ID or a related condition.

Note: The PASRR process cannot be halted if the person has an intellectual disability, regardless of the presence of dementia.

Dementia/MI: Current Concerns

- It would appear that evaluators in many states terminate PASRR as soon as they detect any evidence of dementia. Such termination is typically incorrect for one or both of the following reasons:
 - There is insufficient evidence that dementia is *primary* (as must be the case for individuals with MI); or
 - The diagnosis of dementia is not adequately supported.

Dementia/MI: Current Concerns

- Notably, physicians sometimes indicate that dementia is primary because they wish to accelerate the process of nursing home admission (especially for families experiencing acute distress), and they know that a diagnosis of primary dementia will “short-circuit” PASRR.
- Regardless of physician recommendations, state staff often interpret the CFR to mean that *any* evidence of dementia short-circuits PASRR.

Questions 2 & 3

What criteria do we use when determining if someone's dementia is so severe that they won't benefit from a Level II Evaluation?

- Where is the cutoff?

What are the basic identifiers as far as PASRR/PTAC/Federal Regulations are concerned of someone who is “too impaired” by a neurocognitive disorder to benefit from PASRR, and should be invalidated?

Questions 2 & 3: Considerations

Brief Interview for Mental Status (BIMS)

- 13-15 Cognitively intact.
- 8 –12 Moderately impaired.
- 0 –7 Severe Impairment.

“I don’t think there should be many cutoffs. I think there should be “how can we give individualized assessment and then care recommendations for each person?” It really can’t be about an algorithm.” – Dan Timmel

Question 4

Do we expect those completing the Level I to be able to decipher who is and who isn't "too" impaired?

Question 4: Guidance

- Most Level I screeners have limited expertise in MI and should not be making clinical decisions
- Level I screeners working in hospitals may have added pressures to “fast track” discharges

The Level II evaluation is the point in the PASRR process where decisions should be made that essentially rule out the ability of PASRR to provide valuable guidance for developing a meaningful plan of care.

Question 5

- What questions should we ask of those who are referring, if there are specific identifiers?
- If there aren't, shouldn't we just see everyone so we can make our own determination?
 - This is especially complicated in regards to the regular occurrence of either someone being diagnosed with dementia incorrectly, or someone who clearly has a neurocognitive disorder but has not been diagnosed

Question 5 – Considerations

“I don’t really fancy myself an expert on non-pharmacologic measures but I think maybe, in terms of Dementia, trying to get inside a of person’s world rather than asking that person to come into our world is a theme that I see over and over again.”

Timothy R. Malloy, MD, CMD

PTAC Webinar, “Dementia and PASRR”

January 13, 2015

<http://pasrrassist.org/events/webinar/dementia-and-pasrr>

Question 5 – Considerations

The Level II evaluation offers opportunities to better understand the person:

Understanding certain things that tend to historically set people off and escalate behaviors:

- Responds poorly to crowds (Day room activities)
- Sensitive to noise (Blaring TV)

Understanding behaviors that may have value:

- Paces to relieve tension (OK, unless pacing leads to entering the room of others)

Question 6

For those who don't have a dementia diagnosis but who display significant symptoms, what is the role of PASRR?

- Do we still evaluate them and ask that they receive further evaluation?
- Do we invalidate, but still make recommendations to staff in regards to having them further evaluated and diagnosed?

Question 6: Guidance

Much of what happens is dependent on your PASRR model:

- Evaluation is still focused on determining if the individual's mental illness warrants validation and recommendations. SMI or more broadly focused?
- Recommendations for further evaluation or monitoring related for intensification of dementia symptoms would be appropriate.

Question 7

As far as the “big picture,” is there really no role for PASRR for those folks who have moderate-to-severe dementia with behaviors or mood issues?

- Could this give us the opportunity to make environmental/approach/adaptive recommendations that might help, especially knowing that there are so few resources to help these folks?

Question 7: Considerations

Areas we have been covering reflect the big picture perspective.

- CMS guidance exceeds CFR language
- Knowledge of linkage of primary and behavioral care has grown since CFR Final Rule was issued.
- States are free to exceed the CFR

Question 8

What are some examples of recommendations for someone with dementia who is not appropriate for a psychiatric evaluation, counseling services, or work with PT/OT?

- I have recommended things such as utilizing music as a calming intervention and coloring, but do you have other meaningful interventions to recommend?

Question 8: Considerations

Individualized plans of care stem from a person-centered Level II evaluation. NF plans of care should take into account a range of preferences or interest that will help the person do well in the NF. How much will the NF determine on their own?

- Preferences

- ✦ Specific clothing, color, music, TV programs, food, snacks, drinks, people or privacy

- Interests

- ✦ Family, wildlife, nature, sports

Question 9

Where do we draw the line in order to invalidate dementia?

- A BIMS score of x ?
- A resident that is described as “A&O x1-2”?

Question 9: Considerations

Have the prior Q&A's covered this sufficiently?

- Cut off needs to be limited to most severe instances of dementia that are well supported.
- Guidance for NF plans of care may still be appropriate, based on information/history gathered through the Level II evaluation.

Question 10

Those residents with Lewy Body Dementia may score relatively high on the MMSE, but are definitely lacking in higher executive functioning, including the ability to carry over and retain new information, thus making counseling, for example, impractical.

- They would not benefit from any specialized services above and beyond what is provided by the nursing facilities.

Question 10: Considerations

As has been discussed, if the evaluation confirms that specialized services, beyond what the NF is expected to provide are not expected to provide any benefit, there may still be valuable information for the NF to consider in developing their plan of care.

Comments Submitted

- For those nursing facilities with locked dementia units, it is to be assumed that these facilities are trained to manage the often challenging behaviors associated with advancing dementia.
- For those residents who have a history of SMI (i.e., **depression**) and have advanced dementia (for example, BIMS score of 5/15) we “invalidate” the resident, which is essentially stating that the dementia is significant or severe enough that the person will not benefit from specialized ancillary services (such as counseling).
- This will not prevent the resident from accessing a psychiatric consult through the facility’s contracted MH provider.

Training Resources

Dementia and PASRR Webinar and Q&A Summary

<http://pasrrassist.org/events/webinar/dementia-and-pasrr>

Where PASRR and Dementia Meet Webinar

<http://pasrrassist.org/events/webinar/where-pasrr-and-dementia-meet>

FAQ – What Is the Relationship Between PASRR and Dementia

<http://pasrrassist.org/resources/diagnosis/what-relationship-between-pasrr-and-dementia>