Effective Practices: PASRR Evaluation Reports for Persons with Mental Illness

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Summary of session

- Brief background
- Overview of CMS requirements for evaluation report
- Use of evaluation report to support care/service planning
- Connecticut: One state's experience with PASRR/MI
- Model template for evaluation report
- Discussion/issues

Background: What is PASRR?

- NF Preadmission Screening/Resident Review
- Required for persons with mental illness or intellectual/developmental disabilities
- Purposes:
  - Determine whether NF admission is appropriate
  - Determine whether individual needs specialized services in NF

Background: What is NAPP?

- National Association of PASRR Professionals
- Membership association
- Provides education and technical assistance regarding PASRR
- Works with CMS and the PASRR Technical Assistance Center (P-TAC)
- Goal: Improve impact of the PASRR on lives of persons with mental illness and intellectual/developmental disabilities

Using PASRR Evaluation Reports to Support Person Centered Outcomes

Purpose of the Evaluation Report

- Integrated Assessment Summary?
- Evaluation of Assessment Findings?
- Determination Summary?
- Combination?

Ways to use the Evaluation Report

- Facilitate Person Centered Care
- Define Care Needs for Optimal Health
- Support Appropriate Care and Placement
- Provide Pertinent Information for Care Planning

Contents of PASRR Evaluation Report

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?

Where does the Evaluation Report fit into the PASRR Process?

- Stand-alone document
- Integration with the Level II evaluation
- Integration with PASRR determination documents
- Other?

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
- Level II determination
- Completed by single or multiple professionals

State Differences in PASRR Evaluation Report (cont'd)

What is the format? How is it transmitted?

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

State Differences in PASRR Evaluation Reports (cont'd)

Are there common key components?

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

Care Plan & Service Plan Recommendations:

- Categorical Services
- Rehabilitative Services
- Individualized Care Recommendations

Service Plan Recommendations

Can there be common language to categorize services?

- NF mental health services
- Psychiatric rehabilitative services
- Specialized NF mental health services
- Professional mental health services.

Care Plan Recommendations

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

- Individualized strength based care planning,
- Risk management (environmental, risk of eviction, safety for self and others)
- Pre-crisis planning,
- Service coordination
- Integration with medical care
- Health education and prevention
- Supportive relationships, appropriate activities, and rehabilitation
- Behavioral care planning

What are some common areas in care plan recommendations?

- Support for NF transition
- Discharge planning
- Appropriate placement
- Other

Learning from Other States

- State PASRR web sites
- Identifying state documents
- Practices and guidelines
- Procedure guidelines for PASRR evaluators
- Procedure guidelines for determination of service needs
- Networking
- Conference Calls
- Ideas?

Connecticut Department of Mental Health & Addiction Services

How One State Uses PASRR to Work with Nursing Home Staff & Residents with Mental Illness

Programs for Persons with MI

- Emphasize recovery, psych rehab & home & community-based services.
- Medicaid HCBS Waiver (must meet eligibility requirements).
- Nursing Home Diversion & Transition Program (for clients not eligible for waiver).

NH Diversion & Transition Program

- 8 Nurse Clinicians & 2 Case Managers assigned to geographic locations in state.
- Two levels of responsibility:
  1) Divert clients from unnecessary NF admission.
  2) Transition clients in NFs back to the community.
- Cross-train with mental health waiver requirements.

Link to PASRR

- Trained in PASRR fundamentals
- Access to PASRR data base (track determinations; track LOS; review Level II report; document follow-up)
- Level II report enhances client assessment for discharge planning and/or care planning in NF that will lead to discharge planning
- Review report recommendations with emphasis on recovery & psych rehab
- Ongoing meetings with clients, caregivers, & NF staff.
- Act as client advocates based on needs
- Consult with PASRR vendor
- Provide links to needed services

NAPP Sample PASRR Evaluation Report

Sample Evaluation Report /MI

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; if admitted to a nursing facility, the following services should be considered:

___ Psychosocial rehabilitation
___ Behavior management
___ Individual/group therapy
___ Peer Support/Recovery Services
___ Psychiatric consultation
___ Psychotropic medications
___ Medication education for self-admin.
___ Medication management
___ Structured day program

Other:

_____

_____

_____

Sample 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:

Sample Evaluation Report /MI(cont'd)

Client Name: _____

6. Living Arrangement prior to nursing facility _____
_____

7. What, if any, barriers would make it difficult for the individual to return to the community?
___ 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
___ Other services (specify below)

___ Medication administration
___ Family therapy
___ Family involvement
___ Vocational services
___ Guardian/conservator/POA
___ Peer support/recovery services

_____
_____
_____

—Final Discussion—

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Thank you for participating!