

PASRR

Preadmission Screening and Resident Review

**Best Practices in Serving Individuals
Who Have Positive PASRR Evaluations**

August 2017



TEXAS
Health and Human
Services

Federal Nursing Home Reform Act – OBRA 1987



TEXAS
Health and Human
Services

- Emphasis on all residents' quality of life, requiring:
 - Assessment process leading to individual care plans;
 - Nursing facility (NF) treatment of the whole person; and
 - Services promoting the "highest practicable physical, mental, and psycho-social well-being."
- PASRR



TEXAS
Health and Human
Services

PASRR Requirements

- Every person entering or residing in a Medicaid-certified NF must be screened for possible serious mental illness (MI), intellectual disability (ID), developmental disability (DD), and related conditions (RC).
- Individuals who are identified as having MI, ID, DD, and/or RC are offered the most appropriate long-term care setting for their needs, and receive the services they need in those settings.



TEXAS
Health and Human
Services

PASRR Definition of MI

Mental Illness:

- A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental illness that may lead to a chronic disability. (42 CFR 483 Subpart C, §483.102)

Not Mental Illness:

- Dementia (including Alzheimer's disease or a related disorder)
- Depression (unless major depression)

PASRR Definition of ID/DD/RC

- ID emerged before age 18 (IQ less than 70)
- DD/RC must have:
 - Emerged before age 22
 - Be expected to continue indefinitely
 - Result in substantial functional limitations in **3 or more** of the following major life activities:
 - Self-care
 - Understanding and use of language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living



TEXAS
Health and Human
Services

PASRR Level 1 (PL 1)

DLN Individual

PASRR Level 1 Screening

Section A

Submitter Information (NF/LA only)

A0100. Name <input type="text"/>	
A0200A. Street Address <input type="text"/>	
A0200B. City <input type="text"/>	A0200C. State <input type="text"/>
A0200D. ZIP Code <input type="text"/>	
A0300. NPI/API <input type="text"/>	A0400. Contract No. <input type="text"/>
A0500. Vendor No. <input type="text"/>	A0510. County <input type="text"/>

Purpose:

Identify whether a person *might* have MI, ID, DD, or RC.



TEXAS
Health and Human
Services

PASRR Evaluation (PE)

DLN Individual

PASRR Evaluation

Section A

Submitter Information

A0100. Name

A0200A. Street Address

A0200B. City

A0200C. State A0200D. ZIP Code A0300. NPI/API

A0400. Contract No. A0500. Vendor No.

Evaluation Information

Purpose:

- Identify whether a person has MI, ID, DD/RC.
- Assess whether the person's needs can only be met by NF services or can be met in the community.
- Identify and recommend assessments for all services the person needs to maintain and improve their functioning, *whether in the NF or community.*



TEXAS
Health and Human
Services

PE–Related Best Practices

PASRR Evaluator:

- Ensure all requirements for positive PASRR are met.
- Recommend assessments for all the specialized services the individual *might possibly* benefit from regardless of whether s/he will ultimately receive NF or community services.
(PE sections B0500, B0600, and C1000)
- Identify the individual’s challenges and barriers, as well as strengths and supports, for community living regardless of whether community services or NF services will be recommended. (F0800 I, J, L)
- Identify the services and supports the individual would need to thrive in the community regardless of whether community services or NF services will be recommended.
(F0900 A & B)
- Document that the results of the PE were shared with the individual and LAR on Form 1014.



TEXAS
Health and Human
Services

PL 1 – Related Best Practice

NF Staff:

- Prior to admission, review the NF specialized services recommended in the PE (Section B0600).
- Complete PL 1 Section D0100N to certify whether the NF is willing and able to serve the individual, including providing the recommended specialized services. (TAC Chapter 19, Subchapter BB, 19.2704 (h) (2)).



TEXAS
Health and Human
Services

Section D			
Nursing Facility Choices - 1			
D0100A. Contract No.	<input type="text"/>	D0100B. Vendor No.	<input type="text"/>
D0100C. NPI	<input type="text"/>		
D0100D. Facility Name	<input type="text"/>		
D0100E. Street Address	<input type="text"/>		
D0100F. City	<input type="text"/>	D0100G. State	<input type="text"/>
D0100H. ZIP Code	<input type="text"/>	D0100I. Phone	<input type="text"/>
D0100J. NF Contact First Name	<input type="text"/>	D0100K. NF Contact Middle Initial	<input type="text"/>
D0100L. NF Contact Last Name	<input type="text"/>	D0100M. NF Contact Suffix	<input type="text"/>
D0100N. NF is willing and able to serve individual	<input type="text"/>	0. No 1. Yes	
D0100O. NF Admitted the Individual	<input type="text"/>	0. No 1. Yes	
D0100P. NF Date of Entry	<input type="text"/>		

Service Planning Team (SPT) Meetings

- Required for all individuals who have ID, DD, RC (may also have MI).
- The purpose of SPT meetings is for all members who provide services to regularly meet with the individual and LAR to jointly identify service needs, and to review, discuss, and monitor provided services to ensure the individual is receiving all needed services.



TEXAS
Health and Human
Services

Best Practices: SPT Meetings

- Convened by LIDDA service coordinator (SC) on a quarterly basis *and more frequently if needed*.
- Attended by:
 - SC
 - Individual and/or LAR
 - NF staff member familiar with the individual's needs
 - If NF SS therapies, rehab therapies, day habilitation, behavioral support, independent living skills, employment assistance or supported employment are provided: therapist, DH staff member, BS/ILS/EA/SE provider.
 - If service provider must miss one meeting, s/he provides notes and recommendations.
 - If individual/LAR must miss a meeting, SC documents attempts to schedule at convenient time. SC meets with individual/LAR prior to and after the meeting.
 - Attendance may occur by phone, when needed.



TEXAS
Health and Human
Services

Best Practices: SPT Meetings

First SPT Meeting:

- Review PE thoroughly (in particular, sections B0400, B0500, B0600, C0400, C1000, D0400-D0500, E, and F).
- Identify, review, discuss:
 - Which specialized services (SS) were recommended by the PE?
 - Are there any additional SS the SPT believes the individual should also be assessed for?
 - Have any assessments for SS already occurred?
 - What are the medical services the NF recommended the individual receive?
 - Have any assessments for these already occurred?



TEXAS
Health and Human
Services

Best Practices: Example SC Initial SPT Service Tracking Sheet



TEXAS
Health and Human
Services

Initial Service Planning Team Meeting Name of Individual: Diego R Date: 8/17/2017

NF and LIDDA Specialized Services	PE Recommended?	Should SPT Recommend Assessment?	Reasons Behind Assessments Not Recommended	Date of Assessment
<i>SS OT</i>	<i>N</i>	<i>?</i>		
<i>SS PT</i>	<i>Y</i>	<i>Y</i>		
<i>SS ST</i>	<i>N</i>	<i>?</i>		
<i>APA</i>	<i>N</i>	<i>?</i>		
<i>Behavior Support</i>	<i>Y</i>	<i>Y</i>		
<i>Day Habilitation</i>	<i>N</i>	<i>?</i>		
<i>EA</i>	<i>N</i>	<i>?</i>		
<i>SE</i>	<i>N</i>	<i>?</i>		
<i>ILS</i>	<i>N</i>	<i>?</i>		

*

*

Other Services (From NF POC)	Date of Assessment
<i>Primary Care</i>	
<i>Nursing</i>	
<i>Dental</i>	
<i>Neurology</i>	
<i>Gastroenterology</i>	

*

*

*

*

*

Best Practices: SPT Meetings

Review, discuss and monitor all services, including NF SS and LIDDA SS (if individual has MI, also LMHA/LBHA SS).

- Status of:
 - Any service delivery barriers or delays?
 - Are services delivered with recommended frequency/intensity/duration?
 - ✓ Therapies
 - ✓ Annual nursing and medical assessments
 - Is health being maintained?
 - Are skills being maintained/gained?
- Whether individual and LAR are satisfied with status.
- Which, if any, services need to be revised or removed; whether additional services should be added.



TEXAS
Health and Human
Services

Best Practices: Example SC Service Meeting Checklist – Pt. 1



TEXAS
Health and Human
Services

Service Meeting: SPT Monthly Name of Individual: Ann S Date: 11/13/2017

Service	Date of Most Recent Assessment	Freq/Int/Dur as Required (Y, N, N/A)	Declining / Maintaining / Progressing (D,M, P, N/A)	Description of Concerns or Progress (E.g. description of decline, delay, barrier, or progress)	Indiv Satisfied (Y, N)	LAR Satisfied (Y, N)	Next Steps (E.g., increase in service, decrease in service, addition of service, follow-up with service provider, etc.).	Follow-up Completed
<i>SS OT</i>								
<i>SS PT</i>								
<i>Rehab PT</i>								
<i>Behavior Support</i>								
<i>Day Habilitation</i>								
<i>EA</i>								
<i>CMWC</i>								
<i>DME</i>								
<i>Primary Care</i>								
<i>Nursing</i>								
<i>Dental</i>								
<i>Gastroenterology</i>								

Best Practices: SPT Meetings

Identify, review, and discuss:

- Health-Related Incidents (ER visits, falls, etc.)
- Health-Related Risks:
 - Do any exist?
 - What could be done to mitigate/prevent them?
 - Are those preventive steps in place?
- Meaningful goals for the individual, progress made toward meeting those goals, and next steps. Goals should be based on person-centered planning as well as assessments.
- Collect signatures from all SPT participants



TEXAS
Health and Human
Services

Best Practices: Example SC Service Meeting Checklist - Pt. 2



TEXAS
Health and Human
Services

Service Meeting: SPT Monthly Name of Individual: Ann S Date: 11/13/2017

Health-Related Incidents and Risks	Date(s) of Occurrence	Description of Steps to Mitigate/Prevent	Date Implemented	Indiv Satisfied (Y, N)	LAR Satisfied (Y, N)	Next Steps	Follow-up Completed
<i>Fell from bed when trying to get down on own</i>	<i>3/10/17, 3/20/17</i>	<i>Lowering of bed; mat on floor next to bed</i>	<i>3/21/17</i>	<i>Y</i>	<i>Y</i>	<i>None needed; no additional falls</i>	
<i>UTIs</i>	<i>2/15/17, 3/29/17 5/6/17</i>	<i>(Description)</i>	<i>5/10/17</i>	<i>Y</i>	<i>Y</i>	<i>None needed - has not recurred</i>	
<i>Pressure sore</i>	<i>10/30/17</i>						

Goals	Description of Concern or Progress	Indiv Satisfied (Y, N)	LAR Satisfied (Y, N)	Next Steps (E.g., increase in service, decrease in service, addition of service, follow-up with service provider, etc.)	Follow-up Completed
<i>Be able to walk again</i>	<i>(Rehab PT is focused on walking - see Rehab Notes)</i>				
<i>Get a paying job</i>	<i>(See EA notes)</i>				
<i>Maintain regular contact with family</i>	<i>Has been seeing family on a bi-weekly basis</i>	<i>Y</i>	<i>Y</i>	<i>None needed</i>	

Best Practices: Integration of ISP with NF POC

Ensure the individualized service plan (ISP) is integrated with the NF plan of care (POC):

- SC - Deliver via email or in person copies of the updated ISP to all SPT participants after the meeting is documented.
- NF staff - store copy of updated ISP within the NF POC. Consider creating PASRR section of POC.
- NF staff – clearly identify within the POC responsibilities related to PASRR, such as Specialized Services and Transition.
- SC and NF staff – ensure that NF staff responsible for the individuals' care and plan implementation have read the updated ISP.



TEXAS
Health and Human
Services

Example Integration of ISP into NF POC



TEXAS
Health and Human
Services

Example NF Care Plan Integration of PASRR-Related Responsibilities

Condition	Goal	Approach	Discipline
PASRR positive MI/ID/DD	PASRR-Related Care	Approach State Date: 6/21/17 Assist with SS therapy services as needed. OT sent paperwork to PASRR Unit 6/25/17; awaiting approval.	Nursing, Therapy
		Approach State Date: 6/15/17 Prepare me for attending day <u>hab</u> on Tuesdays and Thursdays, leaving at 9:00 a.m., returning at 4:00 p.m.	Nursing
		Approach State Date: 6/15/17 Notify my Guardian of any changes to my health or care.	Nursing
		Approach State Date: 6/15/17 Make sure my service coordinator is invited to care plan meetings and notified of any changes to my health or care.	Nursing

Summary of PASRR-Related Best Practices

- Recommend evaluations for all specialized services an individual might possibly benefit from.
- Conduct SPT meetings on a quarterly basis, at minimum.
- During SPT meetings (and during monthly meetings with individual and LAR) use a tracking sheet to track:
 - services, assessments, individual's status related to the service, concerns or progress, individual and LAR satisfaction, next steps, and follow-up completion;
 - health-related incidents, and actions being taken to mitigate health-related risks; and
 - the individual's goals, concerns or progress related to goal achievement, next steps needed, and follow-up.
- Make sure the ISP and the NF POC are integrated.



TEXAS
Health and Human
Services



TEXAS
Health and Human
Services

Martha Diase, Ph.D.
Director, Quality Service Review Unit
Quality Monitoring Program and Initiatives
Martha.Diase@hhsc.state.tx.us

August 2017

Coordinating NF Care Planning with Service Plans



TEXAS
Health and Human
Services

Coordination of Care



TEXAS
Health and Human
Services

- NF Care Plan Team
- Coordination of Meetings
- Care Planning and Documentation



Nursing Facility IDT

- Although each PASRR positive resident has a service coordinator assigned to them, the facility must still comply with all rules as laid out by the resident assessment instrument (RAI) for care planning.
- The person at the facility responsible for scheduling and coordination of care plan meetings should also be the person notifying the SC of a meeting scheduled for that resident.



Nursing Facility IDT

- Just as you would send an invitation to an RP or resident, you should send an invitation to the service coordinator to notify them of the need for a meeting.
- This should be documented in the clinical record.
- The service coordinator will also ensure the facility has copies of the required ISPs for each PASRR positive resident. These should be maintained in the clinical record.



TEXAS
Health and Human
Services

Nursing Facility IDT

It is important any new updates to the care plan occurring without a meeting are shared with the SC. The facility is responsible for coordinating how these updates are shared (fax, email, etc.).



Meeting Coordination

- Because you are working with numerous different individuals, meeting coordination is important.
- Remember that the service coordinator does not work in your facility and you might need to be more flexible in your scheduling.
- It is also wise to schedule extra time for these meetings as you may need more time to ensure everyone involved in the care planning understands the care plan (including the resident/RP).



Meeting Coordination

- Make sure you have all of the contact information for the service coordinator and you know the preference for sending updates.
- There are many different ways to coordinate these meetings. They do not always have to be done face-face.
- You can do a conference call, live chat, Skype, email, or fax.
- It is important the SC is involved in any and all care plan discussions for that resident.



Meeting Coordination

- Provide the service coordinator a copy of the NF care plan and any and all updates.
- You should keep all communications in the clinical record. There are no specifications as to where they are kept, but they should be maintained with the care plan notes.
- If your facility is all electronic, most software systems give you the ability to scan in documentation and store it with the electronic record.



Meeting Coordination

- You can scan in the ISP and any notes from the ISP into your electronic chart so it is intact with the clinical record.
- If you still maintain a "hard chart" along with the clinical record, it is recommended to keep these copies with the care plan information.

Care Planning and Documentation



TEXAS
Health and Human
Services

- There are significant differences between an ISP conducted by the PASRR team and the NF care plan.
- The ISP is geared toward numerous topics/concerns and is updated frequently based upon resident needs. It will focus on deficits and potential areas providing the resident with care and services to treat those deficits.

Care Planning and Documentation



TEXAS
Health and Human
Services

- Although the NF care plan also focuses on deficits, the POC is more holistic and identifies all areas of concern instead of specific areas.
- The NF POC will address care areas, any diagnosis requiring monitoring, medications, ADLs, contingency issues, mood, behaviors, and any other issues that need to be addressed.
- The ISP will focus on more specific areas of concern, such as socialization issues, activities, Habilitative Services, and adaptive equipment.

Care Planning and Documentation



TEXAS
Health and Human
Services

- The NF and the SC will maintain separate records, but each should incorporate the other's POC into their own care plans.
- To be truly cohesive, the POC should be merged and not just included into the clinical records for each entity.

Care Planning and Documentation



TEXAS
Health and Human
Services

Let's look at an example:

- A resident is admitted to the facility with a diagnosis of Down syndrome.
- The NF POC will address all of the needs related to this diagnosis, as well as ADLs, nutrition, activities, mobility, etc.
- The ISP might focus on the individual's need to strengthen life skills.
- Therefore, Habilitative services includes plans for OT to work with this resident on skills applicable in a home environment.

Care Planning and Documentation



TEXAS
Health and Human
Services

- The NF should incorporate the Habilitative services into their care plan to show they are supporting those efforts and will monitor the resident's treatments.
- The care plan might read something like the next slide.

Care Planning and Documentation



TEXAS
Health and Human
Services

Problem:

- Mr. Johnson has Down syndrome and needs Habilitative services identified through the PASRR screening.

Goal:

- Mr. Johnson will attend three therapy sessions per week through OT to improve life skills. This will be reviewed every 30 days until the next ISP meeting.

Care Planning and Documentation



TEXAS
Health and Human
Services

Interventions:

1. OT three to five times per week to work on life skills such as maintaining clothing, setting up own ADL assistive devices, and safe mobility.
2. Facility staff will support and encourage independence in ADL care after providing set-up assistance.
3. Care plan review every 30 days as supported by the ISP in coordination with PASRR staff.

Care Planning and Documentation



TEXAS
Health and Human
Services

- As you can see, this is a little different than what you are used, to but it is not complicated.
- This format is much more effective than just adding the ISP to the clinical record.
- This demonstrates true coordination and not just accommodation.

Care Planning and Documentation



TEXAS
Health and Human
Services

- It is up to each NF to coordinate and incorporate the ISP into the NF POC.
- You should ensure you are addressing all of the areas as identified on the ISP and that you demonstrate you are providing the services.

Care Planning and Documentation



TEXAS
Health and Human
Services

- How you document this and where you maintain it are up to each facility.
- It makes sense to include this with the care planning component of your chart.
- Take credit for all you are doing in conjunction with the SPT!
- Document the meetings, conversations, and ISP in your clinical record to show you are providing these necessary services.



TEXAS
Health and Human
Services

Thank you

Shelly Nanney, RN, RAC-CT
MDS Clinical Coordinator, Texas
Shelly.Nanney@hhsc.state.tx.us

(512) 534-1325