

INSTRUCTION MANUAL FOR CARE LEVEL II
PRE-ADMISSION ASSESSMENT
AND RESIDENT REVIEW

MENTAL ILLNESS

Effective November 1, 2010

CARE Program

Client Assessment Referral and Evaluation

CARE LEVEL II PRE-ADMISSION SCREENING FOR PERSONS WITH MENTAL ILLNESS

It is extremely important that KDOA receive a copy of the assessment that is legible in order to review it and make a determination. You will need to go to the Kansas Health Solutions (KHS) website, kansashealthsolutions.org, and download the screening form. An actual interview with the individual being screened (and legal guardian, if appointed) must take place for the assessment to be complete. ALL questions must be answered completely. After completing the form electronically, sign it and fax it to KHS.

For Resident Reviews, please follow the instructions for the questions in Section I- Identification, and Section II- Exclusions, and then proceed to page 33 of the manual for instructions for the rest of the Resident Review. The Pre-Admission Screen and the Resident Review are separate tools.

Date of Complete Referral to Consortium Coordinator

This is the date that the KHS PASRR Coordinator receives the complete referral from the CARE Coordinator. This information is to be filled in or given to you by KSH PASRR Coordinator.

Date Referred to Assessor

State the date that YOU (the Level II assessor) received the referral from KHS. When you receive the Level II referral, determine whether the client has a legal guardian. By federal law you must contact this individual and offer them the opportunity to be present at the interview. You should also note other individuals who are involved in caring for this individual and make every effort to involve them in the assessment as well.

Date of Assessment

The date the assessment is actually done, not the date you fax it to KHS.

Tracking Number

This is a number that KHS uses to track the assessment.

Date Faxed to KSH PASRR Coordinator

This is the date that you FAX the completed assessment to KHS.

SECTION I -IDENTIFICATION

Name

The individual's name in order of last, first, and middle initial.

Phone Number

The phone number at the residential address.

DOB

State the individual's date of birth.

Residential Address

This is the permanent address of the individual being screened. It may be his/her own home or apartment address, a family member's home at which he/she now resides, or the institution or facility where the individual has lived for so long that it is now his/her home. Please fill in street address, city, county, state and zip code completely. Please include the post office box number if there is one.

SSN

Identify the individual's Social Security number in the space provided. If the client does not know/remember his/her Social Security number, check available records for the information. Write "unable to determine" if you are unable to determine the client's Social Security number.

Gender

Identify whether the individual is male or female.

Medicaid Number

State the individual's Medicaid number. Please check the individual's chart for this information. If the individual does not have a Medicaid number, state "none". If a Medicaid number has been applied for, state "number pending".

County of Responsibility

The "county of responsibility" will be the county where the client lived independently or with family (in other than a boarding home, group home, nursing facility, or other supervised living program) for 6 continuous months prior to the latest admission to a state hospital or other institution.

The 6 month period may be waived or extended by agreement by the two mental health centers involved. (If an individual moves to a particular county for the purpose of receiving mental health services, and remains dependent upon those services, then that individual will remain the responsibility of his/her original county.)

Current Location

Include the full name of the facility. If same as “residential address,” state "same" and proceed to “Contact Person.” This is the name of the hospital or facility (example: jail or correctional facility) where the individual is currently residing or is currently a patient.

Ward or Unit

Please give the name of the ward, building, or unit in which the individual is residing if the individual is residing in an institution.

Address

This is the address where the individual is currently residing or the address of the hospital or nursing facility. Please give the complete address, street, city, state and zip code. If there is a post office box, please list it also.

Contact Person

This is the employee at the current facility that is actively involved with the discharge planning of this individual. This person, when contacted, should be able to discuss the current physical and/or mental status of the individual and the steps that have been taken to find a placement for the individual. This person would probably be a discharge planner, case manager, registered nurse, or social worker.

Admission Date

This is the date that the individual was admitted to the current facility.

Phone

This is the phone number of the residence, hospital, nursing facility, or institution where the client is currently residing at the time of the assessment.

Fax number

This is the fax number of the hospital, nursing facility, or institution where the person is currently residing at the time of the assessment. Please attempt to determine if there is a fax number for the floor, ward or unit where the individual is residing, rather than a general institutional number.

Attending Physician Name

State the physician's first and last name. This person will not necessarily be the primary physician. If the person has multiple physicians, state the physician who is caring for his/her immediate needs.

Phone

This is the phone number for the attending physician.

Address

State the complete mailing address for the attending physician. A copy of the outcome letter may be sent to the physician.

Proposed Facility

Identify the facility where the individual intends to reside, if known. State the facility's complete name. Please be specific, i.e. do not write "Medical Haven", be sure to clarify by stating "Medical Haven - Elkhart". If the location is unknown, state "not yet determined."

Contact Person

Please give the name of a person that can be contacted at the proposed facility for information regarding this patient. This individual could be a case manager, social worker, director of nursing, etc.

Address

State the complete address of the proposed facility. Give the street, city, state, and zip code. Give the PO Box if there is one.

Phone number

Identify the telephone number for the admitting facility, including area code.

Fax Number

This is the fax number of the admitting facility, including area code. Please check to be sure that it is the correct fax number.

Proposed Date of Admission

Please give the proposed date of admission to this facility. If the individual has already been admitted to the nursing facility, write the date that the individual was admitted.

Please give the following information about any individual serving as:

Guardian_____ **DPOA**_____ **Other Legal or Medical Representative** _____

Mark the appropriate legal representative using the definitions below.

Guardian means an individual or a corporation appointed by a court to act on behalf of a person who because of both an impairment and the lack of appropriate alternatives for meeting essential needs, has been found to require a guardian. A guardian generally has the authority to take charge of the person known as a ward, and to provide for the ward’s care, treatment, habilitation, education, support and maintenance and to consider and either provide or refuse to provide on behalf of the ward necessary or required consents. A designation as "authorized representative" or as the individual with "power of attorney" is not equivalent to a designation of guardian. Attach a copy of the legal document titled “Letters of Guardianship” which has been filed with the court, if available. The guardian should be contacted and given the option of attending the interview.

DPOA refers to a durable power of attorney. A durable power of attorney means a written power of attorney in which the authority of the individual or corporation designated as attorney-in-fact or agent does not terminate in the event the person who signed the document or principal becomes disabled. Several types of DPOA’s exist. A DPOA may be designated as a durable power of attorney for health care decisions or may be limited to financial matters as specified in the document. The authority of the attorney-in-fact to act for the principal does not begin until whatever conditions set out in the written document have been satisfied.

Name

Identify the name(s) of individual(s) specified as legal representative(s) of this individual.

Address

Identify the full address of individual(s) specified as legal representatives of this individual. Please give the street, city, state and zip code. If the individual has a PO Box listed, please include it.

Home Phone Number

Identify the home telephone number including area code of the individual specified as a legal representative of this individual.

Work Phone Number

Identify the work telephone number including area code of the individual specified as a legal representative of this individual.

Does the individual have another person involved in a significant way, from whom we may be able to obtain additional information about the client's social, medical, emotional, or environmental history and status? Yes _____ No _____

Please mark the appropriate response.

If so, please provide the following information:

Name:

Print the individual's full name.

Address:

Print the individual's complete mailing address, including street, city, state, zip code. If there is a PO Box, please give it.

Home phone number:

Please give the home phone number, including area code, where this person may be reached.

Work phone number:

Please give the work number, including area code, where this person may be reached during the day.

Relationship to Individual:

State the individual's relationship to the client, i.e. friend, mother, spouse, case manager, etc.

SECTION II - EXCLUSIONS

1. **List all diagnoses according to the current DSM manual. Include diagnostic code as well as descriptions. If QMHP disagrees with diagnosis of record please discuss in Clinical Summary section Question #25 at this time.**

This section must include **all** diagnoses. All medical, psychiatric, and cognitive diagnoses must be included. This is important in order to establish categorical determinations.

- a) Does the individual have a major mental illness listed as defined by PASRR on page #7 and #8 of the manual?
Please answer Yes or No.
- b) Does the individual have a primary diagnosis of dementia or a dementia-related disorder listed?
Please answer Yes or No.
- c) Does the individual have a non-primary diagnosis of dementia or a dementia-related disorder AND is the primary diagnosis something other than a major mental disorder?
Please answer Yes or No.

This information should be available in the individual's records. If you have a question as to where dementia is currently fitting into the priority of diagnoses, please consult with the doctor or staff (RN or social worker).

For the purposes of clarity and diagnostic accuracy, a brief discussion of Dementia follows. In the majority of the cases, the diagnosis of Dementia, if applicable, will already be identified.

Examples of dementia and dementia related disorders include: Multi-infarct Dementia, Parkinson's Disease with Dementia, AIDS-related Dementia, Alzheimer's Disease, Senile Dementia, Korsakoff's, and Dementia related to alcohol/substance abuse, Dementia related to a physical condition, etc. ***Please note, in order for an individual to meet this qualification, Dementia must be listed as part of the diagnosis (i.e. Dementia, due to Parkinson's Disease, or Dementia secondary to Parkinson's Disease, not just Parkinson's Disease).***

If you are marking yes, this means the individual will be excluded from future PASRR Level II reviews due to the diagnosis of Dementia.

You must provide verification from clinical records which document Dementia as the primary diagnosis. The required documentation may be in the form of the history and physical, the psychiatric evaluation, discharge summary, progress note updates, medication sheets or care plans that shows the Dementia as the primary diagnosis. Any psychological or neurological testing (MRI, PET or CAT scan, etc.) that is available to you that supports the Dementia diagnosis should be faxed in also.

If supportive documentation of the priority of the Dementia is not faxed with the assessment it will be considered an inappropriate dementia abort.

If the answer to (1a is no) or 1b or 1c is yes, the assessment is finished. Proceed to Section IX.

Proceeding to Section IX at this point in the assessment marks the end of the Level II assessment. The negative response to # 1a indicates the individual does not meet the criteria for PASRR. The affirmative responses to questions #1b or #1c suggest that mental health services are not appropriate for this individual; therefore, the Level II assessment is terminated.

Diagnosis

For the purposes of the CARE Level II PASRR: Mental Illness assessment, only those diagnoses included in the Department of Social & Rehabilitation Services' Department of Mental Health, Substance Abuse Prevention Treatment & Recovery (MHSAPTR) current definition of severe and persistent mental illness (SPMI) can be considered "major mental disorders". No other diagnoses of mental illness will be acceptable when determining an individual's eligibility to receive a CARE Level II PASRR: Mental Illness. Please see the following list of acceptable diagnoses.

Mental Illness

The individual must have a clinical diagnosis of one of the following serious mental illnesses:

- 295.10 *Schizophrenia, Disorganized Type*
- 295.20 *Schizophrenia, Catatonic Type*
- 295.30 *Schizophrenia, Paranoid Type*
- 295.60 *Schizophrenia, Residual Type*
- 295.90 *Schizophrenia, Undifferentiated Type*
- 295.70 *Schizoaffective Disorder*
- 296.23 *Major Depressive Disorder, Single Episode, Severe, without Psychotic Features*
- 296.24 *Major Depressive Disorder, Single Episode, with Psychotic Features*
- 296.32 *Major Depressive Disorder, Recurrent, Moderate*
- 296.33 *Major Depressive Disorder, Recurrent, Severe, without Psychotic Features*
- 296.24 *Major Depressive Disorder, Recurrent, Severe, with Psychotic Features*
- 296.34 *Major Depressive Disorder, Recurrent, in Partial Remission*
- 296.35 *Major Depressive Disorder, Recurrent, in Full Remission*
- 296.89 *Bipolar II Disorder*
- 296. xx *All Bipolar I Disorder*
- 297.10 *Delusional Disorder*

- 298.9 *Psychotic Disorder NOS*
- 300.21 *Panic Disorder with Agoraphobia*
- 300.3 *Obsessive-Compulsive Disorder*
- 301.83 *Borderline Personality Disorder*

NOTE: A diagnosis which is included in the State's definition is not a sufficient determination of eligibility to receive a CARE Level II PASRR: Mental Illness; the following criteria in the Instruction Manual for CARE Level II PASRR Screening: Mental Illness must also be met (questions 2 - 3).

2. **Does the individual have a level of impairment resulting in functional limitations in major life activities, DUE TO HIS/HER MENTAL ILLNESS, within the past 3 to 6 months (interpersonal functioning, concentration, persistence and pace and adaptation to change)?**

Please answer Yes or No.

Level of Impairment:

The disorder results in functional limitations in major life activities within the past three to six months that would normally be appropriate for the individual's developmental stage.

Typically, an individual has at least one of the characteristics in the following areas on a continuing or intermittent basis:

(a) Interpersonal functioning:

The individual has serious difficulty interacting appropriately and communicating effectively with other persons or a possible history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships and social isolation;

(b) Concentration, persistence and pace:

The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks;

(c) Adaptation to change:

The individual has serious difficulty adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

3. **Does the recent treatment history indicate that the individual has experienced at least one of the following?**

- (a) **Psychiatric treatment more intensive than outpatient care more than one time in the past two years (e.g. partial hospitalization or inpatient hospitalization):**

“Psychiatric treatment more intensive than outpatient care” is limited to the following:

1.) hospitalization for more than one day for the primary purpose of providing psychiatric treatment, or 2.) participation for more than one day in a program provided by a mental health entity who defines the program as a "partial hospitalization" psychiatric treatment program. Please note: the individual must receive such services on at least two separate occasions for this box to be checked (unless the individual has remained hospitalized or receiving partial hospitalization treatment for the entire past two years).

OR

- (b) **Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which *supportive services were required to maintain functioning, at home, or in a residential treatment environment, or which resulted in **intervention by housing or ***law enforcement officials.**

An individual is only considered to have met criterion "(b)" if he/she has "experienced an episode of significant disruption to the normal living situation", which is defined as a period of time no less than one month in length during the past two years, during which the individual's mental illness affected them so profoundly as to result in one or more of three situations having occurred:

*"Supportive services..." to maintain functioning... at home or in a residential treatment environment" can be said to have occurred when, during that time period, the individual required a significant increase in services to assist with: instrumental activities of daily living (i.e., shopping, meal preparation, laundry, basic housekeeping, money management, etc.), basic health care (i.e., hygiene, grooming, nutrition, taking medications, etc.), coping with symptoms of extreme withdrawal and social isolation, decreasing incidents of inappropriate social behavior (including: screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior, etc.), decreasing incidents of self harmful behavior.

** "Intervention by housing officials..." can be said to have occurred when the individual has been evicted (including from a shelter) for situations which include inappropriate social behavior (including: screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior, etc.) and abuse or neglect of physical property (including: failure to maintain property as outlined in the lease, intentional destruction of property such as through kicking or hitting walls or doors, etc.). Note: nonpayment of rent, substance abuse, and other such situations can only be included in this category if a direct relationship between the activity and an increase in the severity of the mental illness can be shown.

***"Intervention by law enforcement officials..." can be said to have occurred when the individual has been arrested and/or taken into custody due to: harm to self, others, or property; inappropriate social behavior (including: screaming, verbal harassment of others, physical violence toward others, inappropriate sexual behavior, etc.); or, evidence of impairment so severe as to require monitoring for safety. Note: substance abuse can only be included in this category if a direct relationship between the activity and an increase in the severity of the mental illness can be shown.

Please answer Yes or No.

If the answer to #2 or #3 is no, the assessment is finished, proceed to Section IX.

4. a. **Does the individual have a clinical diagnosis of one or more of the following medical conditions? Check all that apply. Supporting documentation must be attached to this assessment if any of these apply. If none are marked, proceed to #5.**

PARKINSON'S DISEASE HUNTINGTON'S DISEASE
 CHF BRAIN STEM INJURY
 AIDS MULTIPLE SCLEROSIS
 COPD
 AMYOTROPHIC LATERAL SCLEROSIS

If in reviewing medical records you determine the individual has one or more of the above diagnoses, check all that apply. You **must** fax copies of those medical records that document the conditions listed with the assessment. If clinical documentation is not provided you may not mark the above conditions. An aborted assessment cannot be accepted without documentation and will result in significant delays in individual placement and non-payment for assessment.

b. After interviewing the individual, legal guardian, family members, clinical staff, and reviewing the medical records, is it your professional clinical judgment that the medical condition indicated above is of a progressive degenerative nature?

Yes No If No, proceed to #5

The definition of Progressive conditions is as follows:

The medical condition results in a level of impairment so severe that the individual could not be expected to benefit from mental health services. The definition for "level of impairment so severe" would be "a person, who is unable to engage cognitively and emotionally in a therapeutic relationship".

c. **If yes, is the individual being screened currently experiencing increasing levels of deterioration (due to the condition indicated above to the point that the medical condition listed above is the primary factor in determining the needs of the individual and the individual can no longer benefit from specialized services for persons with mental illness?)**

Yes ___ No ___ If No, proceed to #5

If answering yes to this question, you are indicating that the individual's mental health status is as stable as possible and that, compared to the individual's medical needs, their mental health needs are essentially inconsequential. This individual would not and could not receive any benefit from specialized mental health services.

If 4b and 4c are both Yes, the assessment is aborted. Please provide supporting documentation and proceed to Section IX.

If the answers to question #4b and #4c are both yes, this will exclude this individual from PASRR.

PROCEED TO PAGE 33 OF THE MANUAL FOR THE REST OF THE INSTRUCTIONS FOR THE RESIDENT REVIEW

SECTION III - SERVICE/TREATMENT INFORMATION

5. **Is there an active service/treatment, plan in place?** Yes ___ No ___

Please refer to the individual's chart or talk with family and professionals for the service/treatment plan.

If this is a discharge from a state mental health hospital, a community mental health center liaison from the county of responsibility must be involved in the discharge plan.

6. **Is there a community mental health center involved in the service/treatment plan?**

Yes ___ No ___

If this individual is being discharged from a state mental health hospital, the local community health center in the individual's county of responsibility, **must** be involved with the discharge planning.

6a. **If yes, state the name of the CMHC:**

If answering YES, give the name of the community mental health center.

If the answer is **NO**, please explain why it is not involved. For example, the individual has a private psychiatrist or is involved with an outpatient program at a hospital or Veteran's Affairs facility, etc.

6b. Are there other mental health providers involved? Yes ___ No ___

If **YES**, list contact person and phone numbers of those involved and explain.

7. Name and phone number of person who is primarily responsible for the management of this individual's mental health care needs in a community setting:

Please list the name and phone number of person who is primarily responsible for the management of this individual's mental health care needs in a community setting.

8. What is the proposed discharge date?

There needs to be an estimated date of discharge within the next 30 days. This individual should be stabilized enough that there is an active discharge plan in place with a proposed discharge date at the time an assessment is requested. This is important to you, the assessor, because you are making recommendations based upon the status of this individual at the time of your assessment. You are not expected to guess or assume what the client's condition will be several weeks in the future. It is recognized that it sometimes takes awhile to find a nursing facility willing to accept a resident or that it is sometimes necessary to wait for a bed to open , thus the 30 day time frame is allowed. If you have a concern about the assessment recommendations in relation to the discharge date, please discuss it in the clinical summary section, question #25.

9. If the individual is in a facility (i.e. state hospital, jail, rehabilitation or treatment center) what is the discharge planner's name and phone number: Please list the person at the discharging facility who can be contacted for more information regarding this individual. It might be a discharge planner or a social worker. Please give the phone number of this individual, including any necessary extension numbers.

SECTION IV - PRESENTING PROBLEM

10a. Why is this individual being referred for nursing facility admission at this time?

In addition to the determination of the presenting problem, this section requires a review of what community services have already been attempted to address the problem and an explanation of why community services have not been provided, were discontinued, or failed to adequately address the presenting problem. For each category (a, b, c, d, e, f, g, h, and i) that you indicate as applying to the individual being screened, provide additional description under the sections titled "Please explain".

10b. Has the individual received case management assistance, medication assistance, medication reminders, medication drops, or other medication management assistance from a CMHC or other community agency in the past 6 months?

Answer "Yes" or "No" and provide a detailed explanation in the space provided. Indicate the amount of assistance that would be needed and indicate why this assistance could not be provided in the community.

10c. Needs assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL):

Enter the code for each activity of IADL and ADL that indicates the typical level of functioning for this individual during the course of their day in their present setting. Your assessment should be based on your own observation, information from the individual, and information from current care givers or service providers involved in the referral. If the individual uses an assistance device to perform an activity, code the individual's ability with the use of the assistance device and explain in the "Comments" section.

Instrumental Activities of Daily Living

Meal Preparation

Definition: Means the ability to plan, prepare and serve meals.

Coding: **1 = Independent** - Individual able to plan, prepare and serve meals.

2 = Supervision needed - Prepares adequate meals if ingredients are provided. Requires cuing or supervision to ensure that adequate meals are prepared.

3 =Physical assistance needed - Heats and serves prepared meals, or prepares meals but does not maintain an adequate diet. Also use this code for individuals who receive home delivered meals.

4 = Unable to perform - Individual meals are prepared and served by the care giver.

Sample questions: Do you usually fix meals for yourself at home? Can you tell me what you like to fix? How do you go about preparing that? Does anyone help you with that?

Shopping

Definition: Ability to purchase food, clothing, and household items.

Coding: 1= Independent - Able to take care of all shopping needs without assistance.

2 = Supervision needed- Shops independently for small purchases, but needs oversight or supervision for most shopping needs.

3 = Physical assistance needed - Needs to be accompanied on any shopping trip by a care giver.

4 = Unable to perform - Unable to shop.

Sample questions: Are you able to do your grocery shopping for yourself? Where do you like to shop? What kinds of things do you usually get?

Money Management

Definition: Ability to handle own finances.

Coding: 1= Independent - Manages own finances including budgeting, writes checks, pays bills, does own banking; collects and keeps track of income.

2 = Supervision needed - Requires oversight related to financial matters may need to be reminded to pay bills in a timely manner.

3 = Physical assistance needed - Can manage small amounts of money for small purchases but needs assistance with writing checks and balancing check book.

4 = Unable to perform - Incapable of handling finances.

Sample questions: Do you handle your own money or does someone help you with that? Do you write checks to pay your own bills? Are you usually able to save enough money for everything you need at the end of the month?

Transportation

Definition: How individual is able to arrange and obtain transportation for shopping, physician appointments and social activities.

Coding: 1= Independent - Travels independently on public transportation, drives own car or arranges for transportation via taxi or assisted transportation program. Does not require assistance into or out of vehicle.

2 = Supervision needed - Friends or family members provide transportation at the request of or for the individual. If individual uses a wheelchair for mobility, is able to transfer independently into and out of vehicle or can operate wheelchair lift independently.

d = Physical assistance needed - Requires assistance getting into or out of a vehicle.

4 = Unable to perform - Does not travel except with full assistance such as by ambulance.

Sample questions: How do you get to the places you need to go? Have your own car; take a bus, taxi, etc? Does anyone help you with that?

Use of Telephone

Definition: The ability to obtain telephone numbers, dial the phone and answer the phone.

Coding: 1 = Independent - Operates a telephone on own initiative, looks up or obtains and dials numbers, and answers phone without assistance.

2 = Supervision needed - Able to dial well known numbers and answers phone. Needs supervision or cuing to dial infrequently called numbers.

3 = Physical assistance needed - Requires physical assistance to answer and/or dial phone.

4 = Unable to perform - unable to use phone.

Sample questions: Do you have a phone, and are you able to make calls on your own? Who do you call if you need help with something? Where do you keep your important phone numbers?

Laundry, Housekeeping

Definition: Ability to do own laundry and perform housekeeping tasks.

Coding: 1 = Independent - Does personal laundry and maintains home alone or with assistance from a homemaker, chore service or other assistance with work. Assistance is provided no more than one day a week

2 = Supervision needed - With cuing and oversight can do laundry and housekeeping tasks.

3 = Physical assistance needed - Can launder small items and perform light housekeeping tasks such as dusting and dish washing. Other housekeeping and laundry tasks must be performed by someone else. Use this code for individuals who use a portable commode and a care giver is needed to manage the emptying and cleaning of the commode.

4 = Unable to perform - Does not perform laundry or housekeeping tasks.

Sample questions: How do you handle your housekeeping and laundry; does anyone help you with that? Where is the Laundromat closest to you?

Management of Medications/ Treatments

Definition: Ability to self-administer medications and perform treatments as ordered by physician.

Coding: 1 = Independent - Self administers medications in the correct dosage at the ordered times. Performs medical treatments as ordered by a physician.

2 = Supervision needed - Able to self administer medications if prepared in advance or requires cuing and oversight. Use this code for individuals that can self-administer insulin if syringes are pre-filled by a care giver.

Also use this code for individuals who can self administer oral medications when a care giver places doses by time of day and/or week in a pre-filled dispenser. Requires cuing and oversight to ensure that ordered treatments are performed.

3 = Physical assistance needed - A caregiver prepares medications for administration and assists the individual to take medications. Requires some assistance from a caregiver when performing ordered treatments.

4 = Unable to perform - A caregiver is needed to administer medications and to perform all tasks related to ordered treatments.

Sample questions: How do you remember to take your meds or do treatments you physician wants you to do? Does someone set up your meds in pill boxes for you? Does anyone need to remind you to take your meds?

Keep Appointments

Definition: Ability to independently keep scheduled appointments in a timely fashion. Skills involved in this activity include: remembering appointments, managing time and making transportation arrangements.

Coding: 1= Independent - Remembers the appointment and makes arrangements to be there as scheduled.

2 = Supervision needed - Individual requires cuing, oversight or encouragement in order to remember the appointment. Is able to keep appointment if reminded.

3 = Physical assistance needed - Individual requires a care giver to transport and remain with hire at appointment.

4 = Unable to perform - Individual is not able to remember appointments or keep appointments without total assistance from another individuals.

Sample questions: When you have a doctor's appointment, how do you remember to go? Do you go by yourself, or does someone need to go with you?

Seek Medical Help

Definition: The individual's ability to independently seek medical attention and advice. Skills involved in this activity include: identifying medical difficulties, scheduling and attending appointments.

Coding: 1= independent - Individual is able to monitor health needs and initiates appropriate action independently. This includes being able to dial 911 or pressing a "Night Line" button if needed.

2 = Supervision needed - Individual requires cuing, oversight or encouragement in order to recognize a medical need. Can call for appointment, make the appointment and get there without assistance.

3 = Physical assistance needed - Individual needs an individual to help them make an appointment for a medical problem. Needs assistance or help with keeping the appointment.

4 = Unable to perform - Individual neither recognizes the need for medical care nor is able to initiate appropriate service.

Sample questions: If you think you need to see a doctor, what do you do? Does someone help you to make an appointment or do you handle that on your own?

Obtain Housing

Definition: The individual's ability to independently obtain housing. Skills involved in this activity include: researching options, understanding information obtained, and making appropriate decisions based on needs. Consider the individual's history and current living situation in making this determination.

Coding: 1= Independent - Individual is able to complete all aspects of obtaining safe, affordable, and appropriate housing independently.

2 = Supervision needed - Individual needs another person to support them and provide oversight in obtaining housing.

3 = Physical assistance needed - Individual needs another person to actively assist them to find housing. This person is leading the way and providing a lot of guidance in order to find appropriate housing.

4 = Unable to perform - Individual is not able to perform any aspect of finding housing. Would need a care giver to find housing and make all arrangement

Sample questions: Tell me about where you live. Did you find the house (apartment, etc.) on your own or did someone help you with that?

Structuring Free Time

Definition: The individual's ability to independently arrange and participate in activities to meet their leisure, recreational, and social needs during unstructured time when not working or participating in treatment services). Skills involved in this activity include: researching options, understanding information obtained, choosing and participating in preferred activities. Consider the individual's history and that there is a wide range of individual preferences for activity or inactivity during free time. The fact that an individual chooses not to participate in leisure, recreational or social activities, does not necessarily indicate that they are unable to do so.

Coding: 1 =Independent – Individual is able to complete all aspects of identifying, choosing and participating in leisure, recreational, and social activities during unstructured time.

2 = Supervision needed – Individual needs another person to support them and provide oversight in some aspects of structuring free time.

3 = Physical assistance needed – Individual needs another person to provide guidance and actively assist them in identifying and choosing free-time activities, as well as accompanying them to assist with participation.

4 = Unable to perform – Individual is not able to perform any aspect of structuring free time.

Sample questions: What do you like to do in your free time? What do you usually do during the evenings? On weekends? Are you able to do these activities on your own or do you need help with that?

Activities of Daily Living (ADL's)

Bathing

Definition: How the individual takes a full body bath or shower, or sponge bath, and transfers in and out of the tub or shower. Does not include washing back and hair.

Coding: 1 = Independent - Able to bathe self without assistance.

2 = Supervision needed - Requires oversight help only. Oversight includes reminding, preparing bath water, handing individual wash cloth. Individual able to transfer into shower or tub and can bathe self with cuing and oversight.

3 = Physical assistance needed - Individual requires physical assistance getting into bathtub and shower and/or requires some assistance with bathing.

4 = Unable to perform - Individual unable or unwilling to perform any part of the task of bathing.

Dressing Appropriately

Definition: How the individual puts on, fastens, and takes off all items of clothing including donning and removing a prosthesis.

Coding: 1 = Independent - Individual is able to select appropriate clothing and dress self without any assistance. Individuals who use prosthesis are able to apply and remove the prosthesis independently.

2 = Supervision needed - Individual requires oversight, cuing or encouragement to select and/or put on appropriate clothing. Individual requires cuing or oversight to put on prosthesis.

3 = Physical assistance needed - Individual able to perform part of the task of dressing, but requires physical assistance such as guided maneuvering of limbs or other physical assistance.

4 = Unable to perform - Individual is totally dependent on another person for all aspects of the task of dressing.

Toileting

Definition: How the individual uses the toilet (commode, bedpan or urinal), transfers on and off the toilet, cleanses, changes pads, manages ostomy or catheter, adjusts clothing.

Coding: 1 = Independent - Individual is able to perform the task of toileting without assistance, oversight or cuing.

2 = Supervision needed - Oversight, cuing or encouragement required to ensure individual can perform the task of toileting.

3 = Physical assistance needed - Individual may be highly involved in the task of toileting, but physical assistance is required to assure that the task is performed safely. Physical assistance may include adjusting clothing, transferring to and from toilet, help using a urinal or bedpan.

4 = Unable to perform - Individual requires assistance with all tasks related to toileting.

Transfer

Definition: How does the individual move between surfaces: to and from bed, chair, wheelchair, standing position. Do not include moving to and from bath or toilet.

Coding: 1 = Independent - Individual able to transfer self without cuing, oversight or physical assistance

2 = Supervision needed - Oversight, cuing, or supervision is required

3 = Physical assistance needed - Although the individual may be involved in the process of transferring, help is provided such as guides maneuvering of limbs or weight bearing.

4 = Unable to perform - Individual requires full assistance of at least one care giver when transferring.

Walking/Mobility

Definition: Means the ability to move between locations in the individual's living environment. Do not include ability to walk or be mobile outdoors.

Coding: 1 = Independent - Individual requires no oversight, cuing or encouragement to ambulate. Individuals who use a wheelchair are able to be mobile without assistance from another person.

2 = Supervision - Individual requires cuing, oversight or encouragement to ambulate or to be mobile in a wheelchair.

3 = Physical Assistance needed - Individual requires the physical assistance of one or more persons to walk safely. Individual uses a wheelchair and requires another person to move the chair from one place to another

4 = Unable to perform - Individual unable to perform any of the tasks related to ambulation. Use this code for individuals who are bedfast and do not use a wheelchair or other mobility devices.

Note: If the individual has a recent history of falls, it is unlikely that they are independent in walking.

Eating

Definition: How the individual eats and drinks.

Coding: **1= Independent** - Individual able to eat and drink without any cuing, oversight or encouragement.

2 = Supervision - Oversight, cuing or encouragement required to ensure individual eats. Supervision includes ensuring that individuals with dementia eat appropriate food items.

3 = Physical assistance needed - Although individual may be actively involved in the task of eating, physical assistance by another person is required for some of the tasks related to eating.

4 = Unable to perform - Individual unable to perform any of the tasks related to eating and is dependent on a care giver for nourishment. Use this code for individuals who receive their nourishment via intravenous therapy or a feeding tube and are dependent on another individual for the preparation and administration of the feeding.

10. d. Has the individual received case management assistance, attendant care service, skills teaching, or other daily living assistance from a CMHC or other community agency in the past 6 months?

Answer “Yes or No” and provide an explanation, Indicate the amount of assistance that would be needed and indicate why this assistance could not be provided in the community.

10. e. Currently has significant medical needs or need for special treatments requiring 24-hour nursing care.

“Currently” means the needs and behaviors listed are on-going and are causing a need for intervention at the present time.

Check each box that applies. Use the “Other” category to describe medical needs/special treatments not covered by the checkboxes. The “Other” category may include items such as: physical therapy, oxygen, injections, dialysis, wheelchair, walker, meal supplements, assistance technology, etc.

For any items you have identified that would require constant skilled nursing care, describe the specific treatment and medical care that would be needed to maintain the individual’s safety and welfare in the section titled “Please explain”.

10. f. Currently displays behaviors not tolerated by the community.

“Currently” means the needs and behaviors listed are ongoing and are causing a need for intervention at the present time. Check each box that applies

Frequent/continuous yelling

The individual shouts inappropriately.

Verbally abusive or threatening

The individual expresses rude, overly critical or hateful verbalizations.

The individual threatens physical harm to others or to property. Indicate whether threats are directed toward people or objects. In some instances, individual may threaten to hurt others in a nonphysical way. For example, an individual may threaten to "report a staff member for an action." If the verbally threatening behavior is not of a physical nature, please indicate.

Damages/destroys property

The individual throws or breaks objects.

Sexually aggressive/exposes self.

The individual exposes himself/herself by appearing partially nude or removing clothing in public. The individual makes sexually aggressive comments, sexually assaults others or sexually pursues others in a non-reciprocated fashion.

Other

Use the "Other" category to describe any behaviors not listed in the checkbox that have significantly impacted the individual's ability to remain in the community

For any behaviors you have identified that would not be tolerated by the community, describe the specific assistance/supervision that would be needed in the section titled "Please explain" below the check boxes.

10. g. Has the individual received case management, attendant care service, counseling/therapy, or other behavior management assistance from a CMHC or other community agency in the past 6 months?

Please answer "Yes" or "No" and provide a detailed explanation in the space provided. Indicate the amount of assistance that would be needed and indicate why this assistance could not be provided in the community.

10 h. Currently exhibits (within the past 6 months) dangerous behaviors.

Check each box that applies. Use the "Other" category to describe any current dangerous behaviors not listed in the check boxes that have significantly impacted the individual's ability to remain in the community without jeopardizing their own or others' safety and well-being.

Injury to Self

The individual may injure himself/herself in a number of ways: cutting self, frequent falls, burning self, banging head, etc.

Injury to Others

The individual strikes others without just cause and without provocation. The attack is unexpected and/or unwarranted.

Wandering (without regard to safety)

The individual wanders in dangerous settings (i.e. in streets) or near stairs.

Fire Setting

The individual sets fires.

Isolates self (refuses basic nutrition, refuses contact with service providers)

The individual isolates self and refuses basic nutrition and refuses contact with service providers.

Other

For any current dangerous behaviors you have identified, provide additional explanation and describe the specific assistance/supervision that would be needed in order to maintain the safety and well-being of the individual and others in the section titled "Please explain" below the check boxes.

10 i. Did any of the behaviors indicated in the check boxes marked above result in intervention by the following?

Check each box that applies. Use the "Other" category to describe any additional significant interventions or consequences not covered by the check boxes. Examples include: eviction, loss of services, out-patient commitment orders, etc.

For any interventions you have identified, provide additional explanation in the section titled "Please explain". Include a description of the interventions/consequences, dates of occurrences, names of the agencies intervening, and outcomes (was the situation resolved or are there on-going problems?).

This information should be available through medical records, History and Physical, or through the referral source.

The individual may or may not be able to discuss these incidents. If you need clarification, you may want to ask: Can you tell me what happened when the police came to take you to jail (or the hospital, etc.)?

SECTION V - MEDICAL HISTORY AND PHYSICAL

11. Please attach the most recent MEDICAL HISTORY AND PHYSICAL.

Copy the individual's most recent medical history and physical; this history and physical should include information regarding the individual's neurological status in the areas of motor functioning, sensory functioning, deep tendon reflexes, cranial nerves and abnormal reflexes.

This history and physical should have been completed within the last year. However, if the most recent one is older than a year, submit it with a recommendation that the medical history and physical needs to be updated. Sometimes the updated history and physical can be found on progress notes if the individual is currently a resident in a long term care facility.

If the assessment is being done in a home setting, try to obtain a history and physical from the local physician. The physician should already be involved with the referral, since a physician's order is necessary for admission to the nursing facility.

12. List all medications the individual currently takes including over the counter medication, and indicate whether the medication is: S =Stable or A=Being Adjusted

Medication:

This information is contained in the individual's records and also may be verified by verbal report. Please include all medications, not only those medications relevant to the presenting problem. Specify the name of the medication (either trade or technical). Be specific, i.e. do not identify "anti-depressant" rather state "Prozac, Anti-Depressant." Also indicate whether the medication is over-the-counter, "self-prescribed," (taken without close monitoring or instruction from physician) or physician prescribed.

Dosage and Frequency:

Indicate the dosage: dosage refers not only to the amount in terms of milligrams, but also the frequency (i.e. three times a day, as needed, etc.).

S/A

Indicate also whether the dosage identified is stable, or in the process of being adjusted. This information should be available in the individual's records. Stable medications generally have been at a set dosage for a significant period of time to adequately treat the condition. Medications being adjusted will be new medications and/or be in the process of raising or lowering the dosage. For new prescriptions, identify the length of time the individual has been taking the dosage.

Route

Indicate using the following abbreviations:

P.O. - by mouth	IM - intramuscular	SubQ - subcutaneous
S.L. - sublingual	IV - intravenous	

Common abbreviations for time:

QD every day	BID twice daily	TID three times daily
QID four times daily	a.c. before meal	p.c. after meal
Qod every other day	prn as needed	1M one time per month
hs hour of sleep	q4h every four hours	q6h every six hours
am morning	pm night	

13. Please list any medication the individual has taken during the past three months.

Follow the same procedures as outlined in question 12. Include all medications taken in the past three months, except those mentioned in question 12, unless there is a change in dosage. Include information about when the medication was discontinued and, if applicable, why the medication was discontinued.

SECTION VI- PSYCHIATRIC TREATMENT HISTORY

14a. Past Diagnosis (es):

Describe past psychiatric diagnoses the individual has had according to the record.

14. b. Psychiatric Hospitalizations (specify locations, admit/discharge dates, and reasons for admission for the past two years):

List past psychiatric hospitalizations. NOTE: For the **past two years** you must specifically list the admission and discharge dates, location and reason for admissions. This gives credibility for the need for a PASRR Level II assessment for this individual and documents that the individual meets the PASRR criteria for an individual with a serious mental illness.

14. c. History of suicidal or homicidal attempts or ideation:

The individual talks of taking his/her own life or makes veiled suicide threats. The individual specifically threatens to kill himself/herself. The threat may or may not include a suicide plan or note.

14. d. Outpatient Psychiatric Treatment (specify service providers and dates of service for the past two years):

List all past outpatient psychiatric treatment during the past two **years**. You must specifically list the service providers and dates of service. Outpatient treatment includes but is not limited to services such as psychotherapy, CSS day programs, medication management, etc.

15. Have the following intensive mental health community support services been provided in the past two years? Check all that apply:

Indicate whether the individual has received the following intensive mental health community support services in the past two years: Intensive case management, attendant care services, Respite/Crisis stabilization service, Medication assistance (such as medication drops, medication boxes, education, etc.), Residential services (such as a supervised group home, nursing facility, family home, etc.), In-home skills teaching and psycho-social rehabilitation, Home health care services, or any other intensive community based mental health service not listed.

16. Explain why community support services have not been provided or why those services marked above have failed.

Explain why the above-mentioned intensive mental health community supports have not been provided or, if received by the individual, why those services failed.

17. Substance Abuse Treatment (specify service providers and dates of service for the past 2 years):

List all past inpatient/outpatient substance abuse treatment during **the past two years**. You must specifically list the dates of treatments, location, and service providers. Outpatient treatment includes support groups such as AA and NA.

SECTION VII -LIVING ARRANGEMENT AND SUPPORT NETWORK

18. Indicate the individual's preferred living arrangement (individual's choice, not service provider's recommendation.)

Describe the individual's preferred living arrangement (individual's choice, not service provider's recommendation).

19. If there is a legal guardian, do they agree with the individual's choice of living arrangement?

If there is a legal guardian, indicate if they agree with the individual's choice of living arrangement by answering "Yes" or "No". If no, please explain why.

20. The individual currently has a residence available? Please describe.

Indicate by answering "Yes" or "No" if the individual has a residence available. Describe (apartment, house, with family members, etc.)

21. Please check all boxes describing living situations in which the individual has resided since age 18, and indicate the approximate length of time resided and reason individual is not returning to/remaining in living situation:

- Lived Alone in Own Apartment/House/Etc.
- Lived with Relatives/Friends
- Lived in Homeless Shelter and/or Place(s) not meant for Human Habitation
- Lived in Group Home/Transitional Living Center/Treatment Center/
- Assisted Living Facility/Boarding Home
- Living in Nursing Facility/Nursing Facility for Mental Health
- Other

Please explain:

In completing this section, please record the individual's housing history, including length of time resided and reason individual is not returning to/remaining in living situation (for definitions of living situations, see below). If individual has multiple experiences in one category, please indicate.

Example: John lived with his sister for five years. She died, and he couldn't afford to pay the rent on their home. He also lived with his friend, Bill Jones, for three years, until Bill moved out of state - John no longer knows where Bill lives.

"Homeless Shelter" is defined as any entity which defines itself as such, and in which the individual has stayed at least one night.

"Places Not Meant for Human Habitation" includes: streets, cars, parks, and abandoned buildings.

"Transitional Living Center" is defined as any entity not considered a hospital, nursing facility, assisted living facility, treatment center or shelter where more than individual can reside for at least one night, but cannot remain at for more than two years.

"Treatment Center" is defined as any entity which defines itself as such, and which provides treatment for: mental illness, substance abuse, eating disorders, gambling addiction, etc.

"Group Home" is defined as any dwelling licensed by a regulatory agency of this state to provide non-medical care and housing to individuals with a disability. Group Homes are also commonly known as "Residential Care Facilities", "RCFs", and "Transitional Living Centers".

"Boarding Home" is defined as any residential property which includes multiple single room dwelling units which are rented to individuals on a permanent housing basis. The units need not, but may, contain food preparation or sanitary facilities, or both.

"Nursing Facility for Mental Health", or "NFMH" is defined as an entity meeting all of the criteria for "Nursing Facility" as outlined on question 28, and, was designated as a Nursing Facility for Mental Health through a provider agreement with SRS dated June 30, 1994.

22. Individual's Support Network includes:

Family Members - Identify:

Case Manager - Identify:

Guardian or Payee - Identify:

Others - Identify:

Check available supports and provide specific information (Names and phone numbers) in space provided.

23. Support Services and Resources Needed: Check all that apply. Indicate whether they would be available, not available or unknown.

Mark whether the services would be available in the community.

Please explain:

This information should include how much of the service is needed, i.e. Is Attendant Care Services needed 5 hours a week, 5 hours a day, are Medication Drops available 7 days a week, 3 times a day etc.

SECTION VIII - MENTAL STATUS EVALUATION

24. A **mental status evaluation** is the psychological counterpart of a physical examination. It provides specific, accurate information about current behavior and mental capabilities. A review of the individual's current record or chart should assist in the completion of the evaluation. The individual being assessed must be interviewed. Any difficulties with this portion should be discussed in Clinical Summary section, question #25.

SECTION - IX SUMMARY AND FINAL RECOMMENDATIONS

25 Clinical Summary:

The clinical summary should integrate information obtained through a review of the records and clinical interviews. If diagnostic modifications are indicated, document what is included in the record and provide justification for modifications. The summary of information relayed in this section should support your recommendation for the level of care indicated on question #26. If QMHP disagrees with diagnosis of record please document at this time.

26. Mark the appropriate placement/service recommendation:

___ Nursing facility or NFMH level of care **is** needed/Specialized mental health services **are not** needed in acute care psychiatric hospital.

___ Nursing facility or NFMH level of care **is not** needed/Specialized mental health services **are** needed in acute care psychiatric hospital.

___ Nursing facility or NFMH level of care **is not** needed/Specialized mental health services **are not** needed in acute care psychiatric hospital.

The assessor should use clinical judgment in making this recommendation. Stringent guidelines are not appropriate; consider individual differences and conditions. Use the following definitions for nursing facility and specialized services in making your recommendation:

For the purpose of this assessment:

SPECIALIZED SERVICES (Mental Illness): as defined by the Department of Social and Rehabilitation Service (SRS) State Plan, Effective January 1, 1955, are "those services which necessitate the availability of trained mental health personnel from an SRS licensed provider. These services can be provided in the following setting: an acute care psychiatric hospital."(These services are implemented under a plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals that prescribes specific therapies and activities for treatment of persons who are experiencing a acute episode of serious mental illness.

For the purpose of this assessment:

NURSING FACILITY: "any place or facility operating for not less than 24 hours in any week and caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 24 hours a day licensed nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care."

27. Your recommendations are critical to ensuring that this individual receives care and treatments appropriate for their condition. As a QMHP, please give additional mental health services recommendations that would be beneficial for this individual (regardless of above recommendations).

As a qualified mental health professional your recommendations are an important piece of the PASRR process to ensure that the individual with mental illness are receiving those services which are necessary to meet their mental health. A copy of the assessment that you conducted will be supplied to the nursing facility so that your recommendations can be included in the care plan for this individual. They may also be included in the recommendation section of the determination letter (copies of which will be supplied to the NF, doctor, and legal guardian).

Make service recommendations based on a thorough knowledge of resources available in the community in which the individual will be residing in. Obtain this knowledge through community networking and written resources. Your local community mental health centers and the Department of Social and Rehabilitation Services, Mental Health Substance Abuse Prevention Treatment and Recovery 888-582-3759, are excellent resources for information regarding mental health services.

28. What resources were utilized to gather information for this assessment? Include names of individuals and title.

If family member or guardian is not involved in the assessment, please explain why in the remarks section of this question.

Date of interview with the individual (face to face): Enter the date of interview with individual.

Guardian should be included in the assessment!

Guardian and Date Interviewed:

Enter the name of the Guardian that you talked with and the date. Please indicate if the interview was in person or by phone.

If you did not talk with the guardian, document why this was not done and document that guardian was notified by you and declined to attend interview.

Family Members:

Enter the names and relationship of those family members you interviewed in order to obtain information for this assessment. **Family members should be notified prior to assessment and given an opportunity to be involved. If family members were not involved, explain why.**

Health Care Professionals:

Enter the names and titles of those health care professionals that you interviewed in order to obtain information for this assessment. Case manager or discharge planner should be included.

Clinical Records:

List those clinical records, by name and date that you accessed in order to obtain information for this assessment. Examples: Current file (should include orders, progress notes, history and physical, medication sheet, etc. If individual is already a resident in the nursing facility Minimum Data Set (MDS) must be reviewed).

Minimum Data Set (M.D.S.) Version 3.0 - Please note the date of the last Minimum Data Set (M.D.S.) that you reviewed for this assessment.

29. **Exact location of where the assessment took place.**

Please give a description of where this assessment took place. For example: Individual's room, day hall, social service office, etc. Give the name of the facility or hospital where the interview took place. If interview was in individual's own home or home of a care giver, give name of care giver.

SECTION X - QMHP SIGNATURE

Qualified Mental Health Professional Signature

30. **Assessor's Name:**

Your full name (first, middle initial, last) and title.

Assessor's phone number (s):

Provide the telephone number (s) and e-mail address at which you are most accessible during working hours.

Date:

Date the form, only after it is completed in full and is ready to be forwarded for further review.

Assessor's license type and number:

Specify your license type and number.

Assessor's signature:

Sign the form, only after it is completed in full.

Individual's Financial Resources Include:

34SSI/SSDI eligibility

Other income:

Section 8 or other housing assistance, i.e. Alternate Care

Food Stamps

LIEAP

Veterans Benefits

CMHC Flex Funds

Other benefits/formal supports

Check available supports and provide specific information in space provided.

PLEASE NOTE: It is your responsibility to make sure all necessary referrals are made.

Level II MI Resident Review

Be sure follow the instructions for questions in Section I - Identification and Section II – Exclusions.

5. Reason for Resident Review:

Please check the appropriate box, and provide an explanation.

SECTION III - SUMMARY OF TREATMENT SINCE LAST REVIEW

6. Please attach the most recent MEDICAL HISTORY and PHYSICAL from the clinical record.

Copy the individual's most recent medical history and physical; this history and physical should include information regarding the individual's neurological status in the areas of motor functioning, sensory functioning, deep tendon reflexes, cranial nerves and abnormal reflexes.

This history and physical should have been completed within the last year. However, if the most recent one is older than a year, submit it with a recommendation that the medical history and physical needs to be updated. Sometimes the updated history and physical can be found on progress notes if the individual is currently a resident in a long term care facility.

7. Please describe any changes in living arrangements, including hospitalizations, that have occurred since the last review. State the reasons and dates for these changes:

Review the record, interview the individual and staff, and describe any types of changes that have occurred. Examples might be, but are not limited to: change in nursing facility, admission to a psychiatric or medical hospital, change in type of room (private to seem-private), or attempt at community living. If a change has occurred, please give the reason for this change, such as exacerbation of mental illness (describe the behavior), what the medical condition was, or why a room change occurred. If a move to the community was attempted, why did it fail? Please give the dates of the change.

8. Please describe any changes in physical condition (positive or negative) and medical needs of this individual. Include any special needs, equipment, treatment or assistance this individual requires:

Please discuss the current physical status of this individual and his/her medical needs at this time. Include observations of his/her physical condition and how it affects his/her ability to care for self. Include significant medical needs or special treatments such as, but not limited to, physical therapy, oxygen, injections, dialysis, wheelchair, walker, meal supplements, technological assistance, etc.s

9 a). List all medications the individual currently takes including over-the-counter medication, and indicate whether the medication is: S =Stable or A=Being Adjusted

Medication:

This information is contained in the individual's records and also may be verified by verbal report. Please include all medications, not only those medications relevant to the presenting problem. Specify the name of the medication (either trade or technical). Be specific, i.e. do not identify "anti-depressant" rather state "Prozac, Anti-Depressant." Also indicate whether the medication is over-the-counter, "self-prescribed," (taken without close monitoring or instruction from physician) or physician prescribed.

Dosage and Frequency:

Indicate the dosage: dosage refers not only to the amount in terms of milligrams, but also the frequency (i.e. three times a day, as needed, etc.).

S/A

Indicate also whether the dosage identified is stable, or in the process of being adjusted. This information should be available in the individual's records. Stable medications generally have been at a set dosage for a significant period of time to adequately treat the condition. Medications being adjusted will be new medications and/or be in the process of raising or lowering the dosage. For new prescriptions, identify the length of time the individual has been taking the dosage.

Route

Indicate using the following abbreviations:

P.O. - by mouth	IM - intramuscular	SubQ - subcutaneous
S.L. - sublingual	IV - intravenous	

Common abbreviations for time:

QD every day	BID twice daily	TID three times daily
QID four times daily	a.c. before meal	p.c. after meal
Qod every other day	prn as needed	1M one time per month
hs hour of sleep	q4h every four hours	q6h every six hours
am morning	pm night	

9b). Has there been a change in medication since the last review?

Please answer "Yes" or "No. "

If yes, please describe:

Include all medication changes since the last review, including changes in dosage, frequency and route. Include information about when the medication was discontinued, and if applicable, why the medication was discontinued.

10. Have the recommendations listed in the most current PASRR Level II approval letter been addressed? Please photocopy and attach a copy of the letter:

Please answer "Yes" or "No" and explain.

Kansas Department of Aging offers recommendations in their PASRR Level II approval letter in both situations, Pre-Admission Screening and Resident Review. Please review the most recent approval letter to determine if the recommendations have been addressed. If recommendations have not been addressed provide explanation why they have not.

SECTION IV - CURRENT LEVEL OF FUNCTIONING

11. Enter the code for EACH activity of IADL and ADL that indicates the current average level of functioning for this individual during the course of the day in their present setting and indicate any changes.

Enter the code for each activity of IADL and ADL that indicates the typical level of functioning for this individual during the course of their day in their present setting. Your assessment should be based on your own observation, information from the individual, and information from current care givers or service providers involved in the referral. Indicate areas of changes since the last review in the last column by placing a check mark in the box and for those checked; provide an explanation in the space provided.

12a. Complete the Mental Status Evaluation. This is the psychological counterpart of a physical examination. It provides specific, accurate information about current behavior and mental capabilities. A review of the individual's current record or chart should assist in the completion of the evaluation. The individual being assessed must be interviewed.

12b. List any changes since last review (include cognition, memory, orientation, behavior, sensorimotor, social and effect):

In the space provided list any changes since the last review.

SECTION V- CURRENT STATUS

13 Has there been a change since the last review regarding the individual's preferred living arrangement (individual's choice, not service provider's recommendation):

Please answer "Yes" or "No" and describe if the answer is "Yes."

14. If there is a legal guardian, do they agree with the individual's choice of living arrangement?

Please answer "Yes" or "No" and describe if the answer is "No".

15a) Is there is date set for discharge?

Please answer "Yes" or "No." If "Yes", what is the proposed date and where will the individual reside?

15b) Has CMHC case manager been assigned?

Please answer "Yes" or "No"

If yes, indicate the CMHC, case manager's name, and phone number:

If no, please explain:

In the space provided, indicate reason why a case manger has not been assigned.

SECTION - VI - SUMMARY AND FINAL RECOMMENDATIONS

16. Clinical Summary:

The clinical summary should integrate information obtained through a review of the records and clinical interviews. If diagnostic modifications are indicated, document what is included in the record and provide justification for modifications. The summary of information relayed in this section should support your recommendation for the level of care indicated on question #20. If QMHP disagrees with diagnosis of record please document at this time.

17. Mark the appropriate placement/service recommendation:

___ Nursing facility/NFMH level of care **is** needed/Specialized mental health services **are not** needed in acute care psychiatric hospital.

___ Nursing facility/NFMH level of care **is not** needed/Specialized mental health services **are** needed in acute care psychiatric hospital.

___ Nursing facility/NFMH level of care **is not** needed/Specialized mental health services **are not** needed in acute care psychiatric hospital.

The assessor should use clinical judgment in making this recommendation. Stringent guidelines are not appropriate; consider individual differences and conditions. For the purpose of this assessment, use the following definitions for nursing facility and specialized services in making your recommendation:

SPECIALIZED SERVICES (FOR MENTAL ILLNESS): as defined by the Department of Social and Rehabilitation Service (SRS) State Plan, effective January 1, 1995, are "those services which necessitate the availability of trained mental health personnel from an SRS licensed provider. These services can be provided in the following setting:

An acute care psychiatric hospital." (These services are implemented under a plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals that prescribes specific therapies and activities for treatment of persons who are experiencing an acute episode of serious mental illness.)

NURSING FACILITY: "any place or facility operating for not less than 24 hours in any week and caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who by reason of aging, illness, disease or physical or mental infirmity are unable to sufficiently or properly care for themselves, and for whom reception, accommodation, board and skilled nursing care and treatment is provided, and which place or facility is staffed to provide 24 hours a day licensed nursing personnel plus additional staff, and is maintained and equipped primarily for the accommodation of individuals who are not acutely ill and are not in need of hospital care but who require skilled nursing care."

18. Your recommendations are critical to ensuring that this individual receives care and treatments appropriate for their condition. As a QMHP, please give additional mental

health services recommendations that would be beneficial for this individual (regardless of above recommendations).

As a qualified mental health professional your recommendations are an important piece of the PASRR process to ensure that the individual with mental illness or mental retardation/related condition are receiving those services which are necessary to meet their mental health or mental retardation needs. A copy of the assessment that you conducted will be supplied to the nursing facility so that your recommendations can be included in the care plan for this individual. They will also be included in the recommendation section of the determination letter (copies of which will be supplied to the NF, doctor, and legal guardian).

Make service recommendations based on a thorough knowledge of resources available in the community in which the individual will be residing in. Obtain this knowledge through community networking and written resources. Your local community mental health centers and the Department of Social and Rehabilitation Services, Mental Health Substance Abuse Prevention Treatment and Recovery 885-582-3759, are excellent resources for information regarding mental health services.

19. What resources were utilized to gather information for this assessment? Include names of individuals and title. If family member or guardian is not involved in the assessment, please explain why in the remarks section of this question.

Date of Interview with the individual (face to face): Enter date of interview with individual.

Guardian should be included in the assessment!

Guardian and Date Interviewed: Enter the name of the Guardian that you talked with and the date. Please indicate if the interview was in person or by phone.

If you did not talk with the guardian, document why this was not done and document that guardian was notified by you and declined to attend interview.

Family Members: Enter the names and relationship of those family members you interviewed in order to obtain information for this assessment.

Health Care Professionals: Enter the names and titles of those health care professionals that you interviewed in order to obtain information for this assessment. Case manager or discharge planner should be included.

Clinical Records: List those clinical records, by name and date that you accessed in order to obtain information for this assessment. Examples: Current file (should include orders, progress notes, history and physical, medication sheet, etc. If individual is already a resident in the nursing facility Minimum Data Set (M.D.S.) must be reviewed).

Minimum Data Set (M.D.S.) Version 3.0 - Please note the date of the last Minimum Data Set (M.D.S.) that you reviewed for this assessment.

20. Exact location of where the assessment took place.

Please give a description of where this assessment took place. For example: Individual's room, day hall, social service office, etc. Give the name of the facility or hospital where the interview took place. If interview was in individual's own home or home of a care giver, give name of care giver.

SECTION VII - QMHP SIGNATURE

Qualified Mental Health Professional Signature

21. Assessor's Name:

Print your full name (first, middle initial, last) and title.

Assessor's phone number (s):

Provide the telephone number (s) and e-mail address at which you are most accessible during working hours.

Date:

Date the form, only after it is completed in full and is ready to be forwarded for further review.

Assessor's license number:

Specify your license type and number.

Assessor's signature:

Sign the form, only after it is completed in full.

Is this PASRR Level II a courtesy assessment?

Please answer Yes or No.

A courtesy assessment is an assessment performed by an assessor from one CMHC on a person who is either (1) a current consumer of another CMHC, or (2) a person for whom another CMHC is responsible based upon that person's "county of responsibility", refer to page 2 of this manual. When assessor learns that a person being assessed is or should be a client of another CMHC, that Center should be contacted. If an immediate contact is not possible, then the PASRR Level II may be continued and the situation will be discussed with staff of that Center as soon as possible.

During the discussion with staff of the CMHC responsible for the person being assessed, the responsible CMHC's staff person should either: (1) arrange to complete the assessment by sending the assessor to the location of the person or by utilization of some other method, such as interactive TeleVideo, or (2) arrange for the screening to be completed by a assessor from the contacting CMHC. This alternative is referred to as a "courtesy assessment."

A courtesy assessment is commonly required when the person's "county of responsibility" falls within the service area of a CMHC other than the one within which the person comes to the attention of the local assessor.

An important aspect of any PASRR Level II is knowledge of the resources of the person's home community. Since the person performing the courtesy assessment may not be familiar with those resources, "matching" the person's assessed needs with the resources of the home area will be difficult. The assessor must make every effort to contact the responsible CMHC in order to obtain necessary information. If the person being screened does not intend to

return to their “home” community, then the assessor will need to match local resources with the person’s assessed needs.

In any case, a copy of the screening instrument and any admission authorization documents must be faxed to the CMHC which has responsibility for that consumer. In the event that agreement cannot be reached as to which CMHC has responsibility for an individual, the CMHC originally requested to perform the screening must complete that screening and accept temporary responsibility for that consumer. Thereafter, the state mental health authority shall make the final determination.

Date Faxed to responsible CMHC:

Indicate date faxed to responsible CMHC

Contact Person at responsible CMHC:

Indicate staff person at the responsible CMHC who the assessor spoke about the individual being assessed.

23. Time Documentation Summary:

Screen Time: _____ Hours
_____ Minutes

Travel Time: _____ Hours
_____ Minutes

Total Time: _____ Hours
_____ Minutes

Please document the time it took to complete the screen in hours and minutes, whether it was completed in its entirety or aborted.

Individual’s Financial Resources Include

SSI/SSDI eligibility

Other income:

Section 8 or other housing assistance, i.e. Alternate Care

Food Stamps

LIEAP

Veterans Benefits

CMHC Flex Funds

Other benefits/formal supports

Check available supports and provide specific information in space provided.