

PREAMISSION SCREEN RESIDENT REVIEW (PASRR) NYS LEVEL II ADULT MENTAL HEALTH EVALUATION

A. IDENTIFICATION

Assessment Date: _____

Individual's Name: _____

Date of Birth: _____

Medicaid #: _____ PASRR Case #: _____

Current Location: _____

Telephone: _____

Evaluator's Name: _____

Others in Attendance & Relationship to Individual:

B. DOCUMENTATION

The following information is required to complete the assessment. If the information is not provided by the referring entity, the evaluator must obtain the information before proceeding.

_____ A comprehensive history and physical examination, including a complete medical history, review of all body systems, specific evaluation of the individual's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves and abnormal reflexes.

_____ A functional assessment of the individual's ability to engage in ADL's and IADL's. The assessment must address self-monitoring of health status, self-administering and scheduling of medical treatment, including medication compliance, self-monitoring of nutritional status, handling of money, dressing appropriately, and grooming.

_____ Psychosocial evaluation, including current living arrangements, medical and support systems.

_____ A comprehensive psychiatric evaluation, including a complete psychiatric history, evaluation of intellectual functioning, memory functioning and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence and content of delusions) and hallucinations.

_____ PRI or H/C PRI

_____ SCREEN

_____ Physician request for RHCF placement or current RHCF monthly order sheet.

_____ Social Service and Discharge Planning documentation relevant to PASRR request.

_____ RHCF progress notes and psychiatric/applicable consults related to significant change.

C. MEDICAL REVIEW

Medical History: Please check condition(s) that the individual has or has had in the past. (Check all that apply)

- ___ Alcoholism
- ___ Alzheimer/Dementia
- ___ Amputation
- ___ Arthritis
- ___ Anemia
- ___ Cancer
- ___ CVA (stroke)
- ___ Diabetes
- ___ Drug Abuse
- ___ Epilepsy/Seizure Disorder
- ___ Gastric Disease
- ___ Glaucoma/Cataract
- ___ Heart Disease
- ___ High Blood Pressure
- ___ Kidney Disease
- ___ Mental Illness
- ___ Paralysis
- ___ Parkinson's Disease
- ___ Respiratory: Asthma/ Bronchitis/Emphysema
- ___ Skeletal Trauma
- ___ Skin Disease/Ulcers
- ___ TBI
- ___ Thyroid Disease
- ___ Tuberculosis
- ___ Nutritional Deficit
- ___ Other (Specify below):

Please check adaptive equipment that the individual uses:

- ___ Artificial Limb
- ___ Walker
- ___ Cane
- ___ Bedside Commode
- ___ Wheelchair
- ___ Hospital Bed
- ___ Other (specify)

Comments: _____

D. MENTAL HEALTH EVALUATION

Complete this section based upon the documentation provided and interview with the individual and/or the individual's representative.

1) Does the individual have a diagnosed mental health problem or a history of receiving mental health services within the past two years?

_____ 1=Yes
2=No

2) If the answer to question D.1 is **Yes**:

a. Indicate where the mental health services were provided and with what frequency in the past 30 days.

b. Below, list the specific mental health services that the individual is currently receiving. Specify the professional title of the individual providing the mental health service (MSW, psychologist, psychiatrist, etc.).

3) **Indicate, using the scale provided, if the individual exhibits the following behaviors.**

1=No problem 2=Minor problem 3=Moderate problem 4=Serious problem

- _____ Emotional withdrawal
- _____ Depressive mood
- _____ Suspiciousness
- _____ Uncooperativeness
- _____ Inappropriate behavior in group settings
- _____ Takes others' property without permission
- _____ Reacts poorly to criticism, stress or frustration
- _____ Has a problem/history of drug/alcohol abuse

4) Identify positive and negative behavioral traits, including a description of current attitudes and mood:

5) **Memory Deficit:**

Known history of forgetful behavior that is dangerous to self or others:

- _____ 1=No/minimal problem
- 2=Occurs less than once per week
- 3=Occurs once per week or more or a special problem exists

6) **Impaired Decision Making:** Makes seriously inappropriate decisions or unable to make decisions regarding routine matters - not due to lack of knowledge.

- _____ 1=No/minimal problem
- 2=Occurs less than once per week
- 3=Occurs once per week or more or a special problem exists

7) **Delusions/Hallucinations:** Experienced at least once per week during the past four weeks, visual, auditory or tactile perceptions that have no basis in external reality.

- _____ 1=Yes
- 2=No

If yes, describe the content of the delusions/hallucinations: _____

8) **Orientation:** Ability to identify familiar people, to recognize date and time, and to recognize the environment.

- _____ 1=Good mental clarity, generally oriented to time, place and person
- 2=Occasional episodes of disorientation (i.e., 1-3 days during the past month)
- 3=Frequent episodes (i.e., once per week during the past month but not daily)
- 4=Daily intermittent episodes of disorientation
- 5=Total disorientation on a daily basis

9) Wandering: Unsafe roaming without purpose and without regard to safety.

- _____
- 1=Does not wander
 - 2=Wanders safely
 - 3=Occasionally (i.e., less than once per week) jeopardizing safety
 - 4=Frequently (i.e., at least once per week) jeopardizing safety

10) Verbal Disruption: Yelling, baiting, threatening.

- _____
- 1=None in the past four weeks
 - 2=Occurred in past four weeks but not at least once per week
 - 3=Predictable behavior occurred in past four weeks regardless of frequency
 - 4=Unpredictable, disruptive behavior at least once per week but not daily
 - 5=Daily episodes of unpredictable, disruptive behavior

11) Disruptive, Infantile or Socially Inappropriate Behavior: Childish, repetitive or anti-social physical behavior that creates disruption to others. Does not include verbal abuse.

- _____
- 1=None in the past four weeks
 - 2=Occurred in past four weeks but not at least once per week
 - 3=Predictable behavior occurred in past four weeks regardless of frequency
 - 4=Unpredictable, disruptive behavior at least once per week but not daily
 - 5=Daily episodes of unpredictable, disruptive behavior

12) Physical Aggression: Combative or assaultive to self or others.

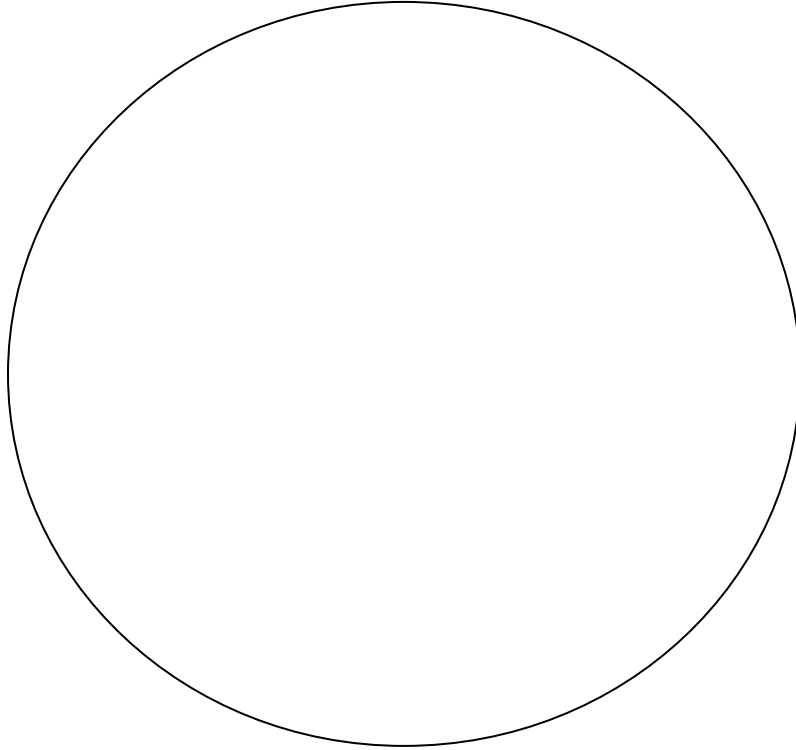
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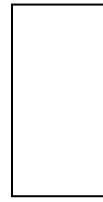
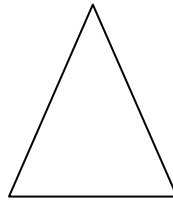
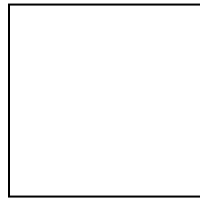
13) Danger to Self or Others: Based on your interview with the individual (and/or available informants), and/or a review of this individual's medical record, is there any evidence to suggest that this individual is, or may have been, a danger to self or others during the past two years?

- _____
- 1=Yes
 - 2=No

E. SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS) EXAMINATION

- ___ 1) What day of the week is it? (1 point for the right answer)
- ___ 2) What is the year? (1 point)
- ___ 3) What state are we in? (1 point)
- 4) Please remember these five objects. I will ask you what they are later:
- Apple, Pen, Tie, House, Car. (No points yet)
- ___ 5) You have \$100 and you go to the store and buy a dozen apples for \$3 and a tricycle for \$20.
- How much did you spend? (1 point)
 - How much do you have left? (2 points)
- ___ 6) Please name as many animals as you can in one minute. (No point for naming 0-4; 1 point for naming 5-9; 2 points for naming 10-14; and 3 points for naming 15 or more.)
- ___ 7) What were the five objects I asked you to remember? (1 point for each object remembered.)
- ___ 8) I am going to say a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
- 87 (0 points)
 - 649 (1 point)
 - 8537 (1 point)
- ___ 9) (Draw circle.) This circle represents a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
- (2 points for hour markers labeled correctly)
 - (2 points for correct time)
- ___ 10) (Show a triangle, a square and a rectangle.) Please place an X in the triangle. (1 point)
- ___ 11) Which of those objects is the largest? (1 point)
- 12) I am going to tell you a story. Please listen carefully because afterward, I'm going to ask you some questions about it.
- Jill was a very successful stockbroker. She made a lot of money in the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped working and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.
- ___ What was the female's name? (2 points)





F. PSYCHOSOCIAL/FUNCTIONAL EVALUATION

- 1) Describe the individual's usual living arrangements, including the names and types of facilities involved:

- 2) Describe any factors pertaining to the patient's psycho-behavioral status that relate to the individual's potential site of placement, including medical and support systems:

- 3) Identify positive traits, developmental strengths and/or weaknesses, and developmental needs:

- 4) Based on the PRI or H/C PRI:

What is the Activities of Daily Living (ADL) score? _____

What is the RUG II score? _____

- 5) Does the individual have a diagnosis of Traumatic Brain Injury (TBI)?

YES____ **NO**____

If yes, has placement in a neurobehavioral facility been considered?

YES____ **NO**____

Please describe: _____

G. SERIOUS MENTAL ILLNESS

Based upon this Level II evaluation, is there sufficient evidence that the individual may have a serious mental illness as set forth in 42 CFR 483.102?

YES____ **NO**____

If no, explain below. The evaluation ends. Proceed to the PASRR Level II Evaluation Report.

H. EVALUATING THE NEED FOR NURSING FACILITY SERVICES AND NURSING FACILITY LEVEL OF CARE

1) Has the individual had prior attempts at community placement?

YES____ **NO**____

a. If yes, how many? _____

b. Describe this individual's history of community placement, including unsuccessful placement(s): _____

2) Based on the information available and your evaluation, do you agree or disagree with the SCREEN referral recommendation (item 21)?

AGREE _____ **DISAGREE** _____

Explain: _____

3) The individual's total needs are such that his or her needs can be met in the appropriate community setting;

YES____ **NO** _____

- 4) The individual's total needs are such that they can be met through placement in a home and community-based waiver program, and such a program is available to the individual. A waiver program provides support and services to assist individuals with disabilities and seniors towards successful inclusion in the community, when otherwise inpatient care would be required.

YES ___ NO ___

- 5) The individual's total needs are such that placement in a home and community based waiver program was considered, but determined not to be appropriate or feasible at this time. Inpatient care is appropriate and desired, and the nursing facility is an appropriate setting for meeting the individual's needs in accordance with 42 CFR 483.126;

YES ___ NO ___

- 6) If the answer to item 5 is yes, are any services of lesser intensity (SLI) recommended?

YES ___ NO ___

If yes, check the level of SLI recommended, and in the space provided document the findings supporting your recommendation:

SLI Level 1 _____

SLI Level 2 _____

SLI Level 3 _____

- 7) If inpatient care is appropriate and desired, but the nursing facility is not the appropriate setting for meeting the individual's needs in accordance with 42 CFR 483.126, another setting such as an Institution For Mental Diseases (IMD) providing services to individuals aged 65 and older, or a psychiatric hospital may be an appropriate institutional setting for meeting those needs.

YES ___ NO ___ **If yes, refer to IPRO physician for specialized services review.**

Summary of Findings: _____

Signature of Evaluator (Reviewer): _____ **Date:** _____

I. SPECIALIZED SERVICES REVIEW

A functional behavioral impairment has been identified which requires review for **SPECIALIZED SERVICES** (Active Treatment) by the Office of Mental Health. The current psychiatric diagnosis and DSM code is: _____

Psychiatrist Signature: _____ **Date:** _____

OR

A review for **SPECIALIZED SERVICES** (Active Treatment) by the Office of Mental Health is not required.

Psychiatrist Signature: _____ **Date:** _____