DHS Med-QUEST
PASRR-Preadmission Screening
Resident Review Training

Agenda

1. History
2. Requirements and regulations
3. PASRR process
4. PASRR Level I Part A, B, and C
5. PASRR Level II forms and process
6. Resident review
7. Compliance reviews & responsibilities of facilities
8. ePASRR training resources

PASRR Level I

STATE OF HAWAII
Department of Human Services

Med-QUEST Division

PREADMISSION SCREENING RESIDENT REVIEW (PAS/RR) LEVEL I SCREEN	PATIENT'S NAME: (Last Name, First, M.I.)	DATE OF BIRTH: (MM/DD/YY)
	PRIMARY DIAGNOSIS:	MEDICAID I.D. NUMBER:
	REFERRAL SOURCE: (Physician's Name; Nursing Facility; Hospital; Etc.)	

PART A: SERIOUS MENTAL ILLNESS (SMI): YES NO

1. The individual has symptom(s) and/or a current diagnosis of a Major Mental disorder and/or a Substance Related disorder, which seriously affects interpersonal functioning (difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others), and/or completing tasks (difficulty completing tasks, required assistance with tasks, errors with tasks; concentration; persistence; pace), and/or adapting to change (self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, withdrawal): ( ) ( )
   a. A **SCHIZOPHRENIC** disorder, **MOOD** disorder, **DELUSIONAL (PARANOID)** disorder, **PANIC OR OTHER SEVERE ANXIETY** disorder, **SOMATOFORM** disorder, **PERSONALITY** disorder, **SUBSTANCE RELATED** disorder or **PSYCHOTIC** disorder not elsewhere classified that may lead to a chronic disability; **BUT**
   b. **NOT** a primary or secondary diagnosis of **DEMENTIA**, including **ALZHEIMER'S DISEASE OR A RELATED DISORDER.**
2. Does the SMI individual have Dementia? If yes, include evidence/presence of workup, comprehensive mental status exam. ( ) ( )
3. Has psychoactive drug(s) been prescribed on a regular basis to treat behavioral/mental health symptom(s) for the individual within the last two (2) years with or without current diagnosis of SMI? ( ) ( )

PART B: INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITIES (ID/DD): YES NO

1. The individual has a diagnosis of **ID** or has a history indicating the presence of **ID prior** to age 18. ( ) ( )
2. The individual has a diagnosis of **DD/related condition** (evidence/affects intellectual functioning, adaptive functioning; autism, epilepsy, blindness, cerebral palsy, closed head injury, deaf) or has a history indicating the presence of **DD prior** to age 22. Age of diagnosis/presence: _____ ( ) ( )
3. Does the ID/DD individual have a primary diagnosis or presence of **Dementia**? If yes, include evidence/presence of Dementia work-up, comprehensive mental status exam, if available. ( ) ( )
4. The individual has functional limitations relating to **ID/DD** (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently). ( ) ( )
5. The individual received/receives **ID/DD** services from an agency serving individuals with ID/DD; (past and/or present; referred/referrals). Describe past AND present receipt of services and referrals made from agencies that serve individuals with ID/DD. _____ ( ) ( )

DETERMINATION:

1. If any of the answers in Parts A or B are **YES,** COMPLETE PART C (page 2) of this form.
2. If all of the answers in Parts A or B are **NO, SIGN** and **DATE** BELOW:

LEVEL I SCREEN IS NEGATIVE FOR SMI OR ID/DD THE PATIENT MAY BE ADMITTED TO THE NF:	DATE AND TIME COMPLETED:
SIGNATURE OF PHYSICIAN, APRN, HOSPITAL DC PLANNER RN	MM/DD/YY
PRINT NAME	Time

DHS 1178 (Rev. 07/18) Page 1 of 2 (over)

Page 1

PASRR Level I

PART C:		YES	NO
1.	Is this individual being discharged from an acute care hospital and admitted to the NF for recovery from an illness or surgery **not to exceed 120 days** and is not considered a danger to self and/or others?	( )	( )
2.	Is this individual **certified** by his physician to be terminally ill **(prognosis of a life expectancy of 6 months or less),** serviced by a certified, licensed hospice agency at the time of admission and is not considered a danger to self and/or others?	( )	( )
3.	Is this individual comatose, ventilator dependent, functioning at the brain stem level or diagnosed as having a **severe physical illness,** such as, COPD, Parkinson's Disease, Huntington's Chorea, or amyotrophic lateral sclerosis; which result in a level of impairment so severe that the person cannot be expected to benefit from specialized services?	( )	( )
4.	Does this individual require **provisional admission** pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears?	( )	( )
5.	Does this individual require **provisional admission which is not to exceed 7 days,** for further assessment in emergency situations that require protective services?	( )	( )
6.	Does this individual require admission for **a brief stay of 30 days for respite care**? The individual is expected to return to the same caregivers following this brief NF stay.	( )	( )

CHECK ONLY ONE:

[ ] If **any** answer to Part C is **Yes, NO REFERRAL for LEVEL II** evaluation and determination is necessary at this time. **NOTE TIME CONSTRAINTS!**

[ ] If **all** answers to Part C are **No, REFERRAL for LEVEL II** evaluation and determination **MUST BE MADE.**

SIGN and DATE this form.

	DATE & TIME COMPLETED:
SIGNATURE OF PHYSICIAN, APRN, HOSPITAL DC PLANNER RN	**MM/DD/YY**
PRINT NAME	**Time**

Page 2

PASRR—History

- Due to the institutional mental health facility closures or downsizing in the 80s:
  - Individuals with a serious mental illness (SMI) or/and intellectual disabilities or developmental disabilities or related condition (ID, DD, RC) were institutionalized in nursing facilities (NF) without adequate mental health services
- Omnibus Budget Reconciliation Act (OBRA) 1987—Congress created Preadmission Screening & Resident Review (PASRR)

General Requirements & Regulations

PASRR

- **Preadmission screening requirements**
  - Applies to all Medicaid-certified nursing facilities
  - Applies to all individuals being admitted regardless of payor source
  - Needs to be completed prior to admission
  - Needs to be completed by a physician, APRN, or hospital discharge planner RN

General Requirements & Regulations

Purpose

To determine the following:

- If the individual has a SMI, ID, DD, RC
- If the individual requires the level of services provided by NF
- If individual requires specialized psychiatric services

  Determination must be made by the State mental health authority:

  Department of Health (DOH) Adult Mental Health Division (AMHD) or Developmental Disabilities Division (DDD), unless the individual meets criteria for Categorical Determination

SMI-Serious Mental Illness DD-Developmental Disability
ID-Intellectual Disability RC-Related Condition

General Requirements & Regulations

Specialized Services for SMI, ID, DD, RC

Active treatment: Continuous and aggressive implementation of an individualized plan of care. Developed and supervised by interdisciplinary team.

SMI-Serious Mental Illness DD-Developmental Disability
ID-Intellectual Disability RC-Related Condition

General Requirements & Regulations

PASRR

Resident Review—while in nursing facilities

- Required for significant change in an individual
- May require a Level 2 to be completed

Process will be further described later in the presentation

General Requirements & Regulations

CMS Review of Hawaii's PASRR Process

Findings:

- Gap in screening vs. reporting data in Minimum Data Set (MDS)

Recommendations:

- Must "broadly screen" individuals

Actions:

- Hawaii added additional screeners: Hospital RN Discharge Planners and APRNs
- Level II Evaluation Forms revised
- Level I Forms revised
- Data reporting
- ePASRR (Hawaii's Web-based application)

PASRR Process

Referring Entity: Completes 1178 Level 1

↓

Negative Level 1 Part A/B

↓

Admit to NF

OR

Referring Entity: Completes 1178 Level 1

↓

Positive Level 1 Part A/B

↓

Complete Part C

PART A: SERIOUS MENTAL ILLNESS (SMI):	YES	NO
1. The individual has symptom(s) and/or a current diagnosis of a Major Mental disorder and/or a Substance Related disorder, which seriously affects interpersonal functioning (difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others), and/or completing tasks (difficulty completing tasks, required assistance with tasks, errors with tasks; concentration; persistence; pace), and/or adapting to change (self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, withdrawal):	( )	( )
a. A **SCHIZOPHRENIC** disorder, **MOOD** disorder, **DELUSIONAL (PARANOID)** disorder, **PANIC OR OTHER SEVERE ANXIETY** disorder, **SOMATOFORM** disorder, **PERSONALITY** disorder, **SUBSTANCE RELATED** disorder or **PSYCHOTIC** disorder not elsewhere classified that may lead to a chronic disability; **BUT**		
b. **NOT** a primary or secondary diagnosis of **DEMENTIA**, including **ALZHEIMER'S DISEASE OR A RELATED DISORDER.**		
2. Does the SMI individual have Dementia? If yes, include evidence/presence of workup, comprehensive mental status exam.	( )	( )
3. Has psychoactive drug(s) been prescribed on a regular basis to treat behavioral/mental health symptom(s) for the individual within the last two (2) years with or without current diagnosis of SMI?	( )	( )

PART B: INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITIES (ID/DD):	YES	NO
1. The individual has a diagnosis of **ID** or has a history indicating the presence of **ID prior** to age 18.	( )	( )
2. The individual has a diagnosis of **DD/related condition** (evidence/affects intellectual functioning, adaptive functioning; autism, epilepsy, blindness, cerebral palsy, closed head injury, deaf) or has a history indicating the presence of **DD prior** to age 22. Age of diagnosis/presence: ____	( )	( )
3. Does the ID/DD individual have a primary diagnosis or presence of **Dementia**? If yes, include evidence/presence of Dementia work-up, comprehensive mental status exam, if available.	( )	( )
4. The individual has functional limitations relating to **ID/DD** (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently).	( )	( )
5. The individual received/receives **ID/DD** services from an agency serving individuals with ID/DD; (past and/or present; referred/referrals). Describe past AND present receipt of services and referrals made from agencies that serve individuals with ID/DD. _____	( )	( )

PASRR Process

Complete Part C- Categorical Determination

Part C—All No's

Complete Level 2

OR

Part C—1 Yes

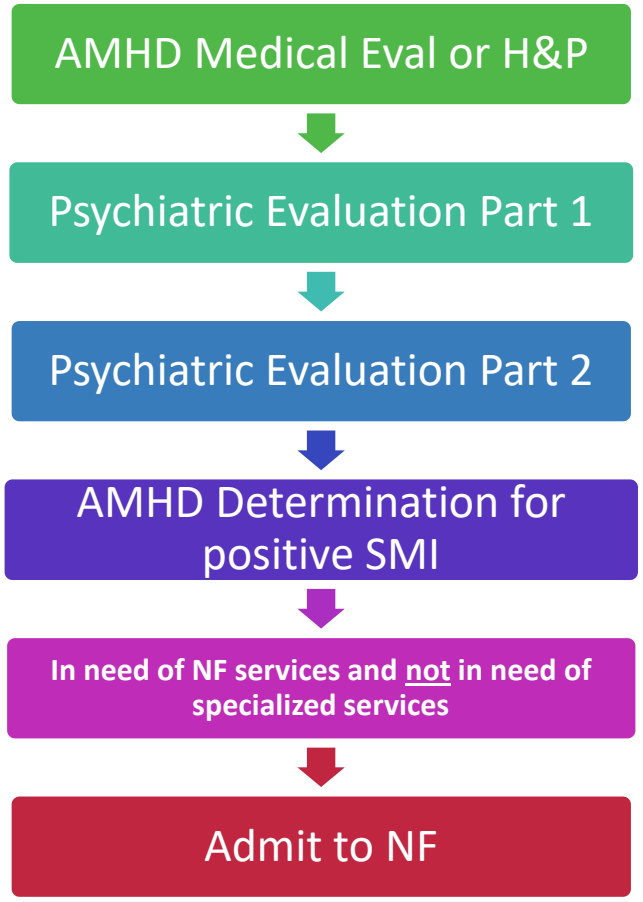
Admit to NF

PART C:		YES	NO
1.	Is this individual being discharged from an acute care hospital and admitted to the NF for recovery from an illness or surgery **not to exceed 120 days** and is not considered a danger to self and/or others?	( )	( )
2.	Is this individual **certified** by his physician to be terminally ill **(prognosis of a life expectancy of 6 months or less),** serviced by a certified, licensed hospice agency at the time of admission and is not considered a danger to self and/or others?	( )	( )
3.	Is this individual comatose, ventilator dependent, functioning at the brain stem level or diagnosed as having a **severe physical illness,** such as, COPD, Parkinson's Disease, Huntington's Chorea, or amyotrophic lateral sclerosis; which result in a level of impairment so severe that the person cannot be expected to benefit from specialized services?	( )	( )
4.	Does this individual require **provisional admission** pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears?	( )	( )
5.	Does this individual require **provisional admission which is not to exceed 7 days,** for further assessment in emergency situations that require protective services?	( )	( )
6.	Does this individual require admission for **a brief stay of 30 days for respite care**? The individual is expected to return to the same caregivers following this brief NF stay.	( )	( )

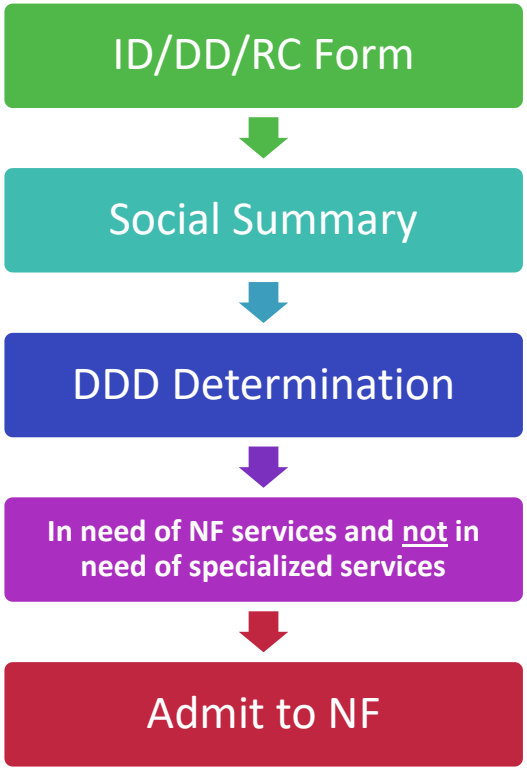
PASRR Process

PASRR Process

Level 2 for SMI (Level 1 Part A positive)



Level 2 for ID/DD/RC (Level 1 Part B positive)

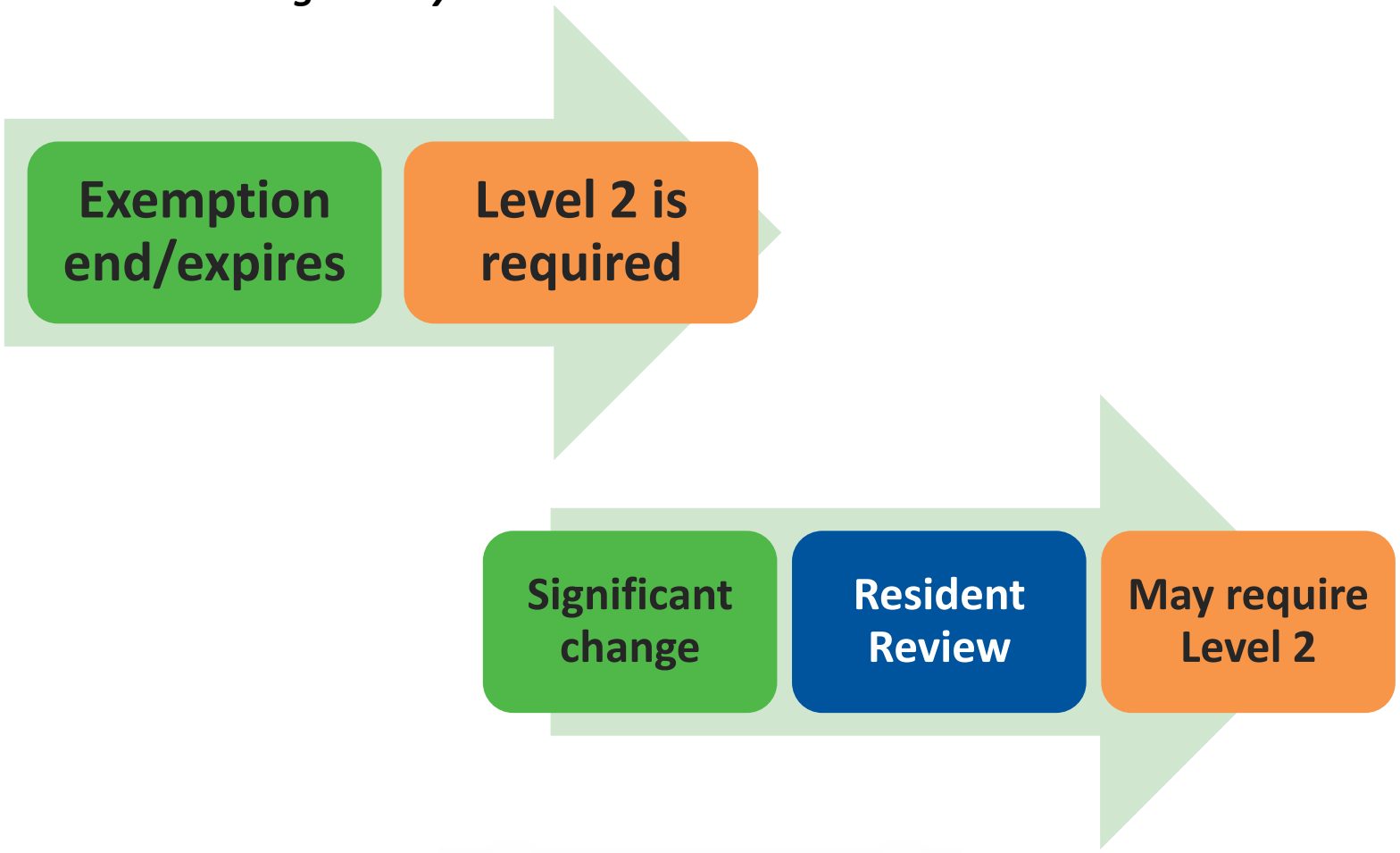


AMHD: Adult Mental Health Division
SMI: Serious mental illness

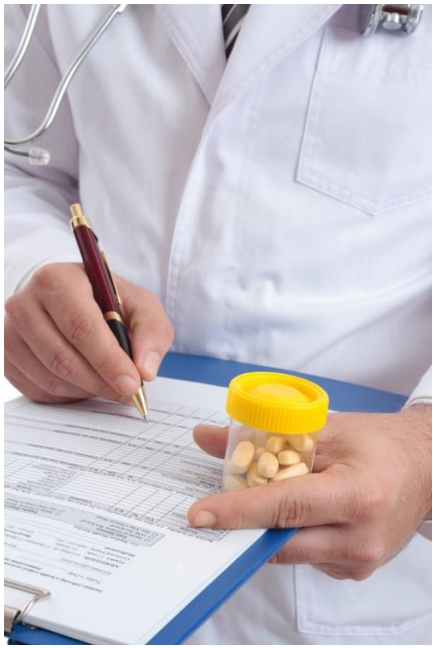
ID/DD/RC: Intellectual Disability/Developmental Disabilities & Related Condition
DDD: Developmental Disabilities Division

PASRR Process

While in the Nursing Facility



Level 1 (1178) Form



Level 1 Part A

PART A: SERIOUS MENTAL ILLNESS (SMI)

1. The individual has symptom(s) and/or current diagnosis of a Major Mental disorder and/or a Substance Related disorder, which seriously affects interpersonal functioning (difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others), and/or completing tasks (difficulty completing tasks, required assistance with tasks, errors with tasks; concentration; persistence; pace), and/or adapting to change (self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, withdrawal):

    a. A **SCHIZOPHRENIC** disorder, MOOD disorder, **DELUSIONAL (PARANOID)** disorder, **PANIC OR OTHER SEVERE ANXIETY** disorder, **SOMATOFORM disorder**, **PERSONALITY** disorder, **SUBSTANCE RELATED** disorder or **PSYCHOTIC** disorder not elsewhere classified that may lead to a chronic disability; **BUT**

    b. **NOT** a primary or secondary diagnosis of **DEMENTIA**, including **ALZHEIMER'S DISEASE OR A RELATED DISORDER.**

Level 1 Part A

PART A #1 KEY POINTS FOR POSITIVE ANSWER

- Mental disorder and/or symptoms are current
- Mental disorder may lead to a chronic disability
- The level of impairment seriously affects the individual's interpersonal functioning, completing tasks, or adapting to change
- Mental disorder is a "stand alone" diagnosis, behavior or mental health condition is not primary or secondary to Dementia

Level 1 Part A

PART A (cont.)

2. Does the SMI individual have Dementia? If yes, include evidence/presence of workup, comprehensive mental status exam.

   If question 1 is a "No," you do not need to answer question 2

3. Has psychoactive drug(s) been prescribed on a regular basis to treat behavioral/mental health symptom(s) for the individual within the last two (2) years with or without current diagnosis of SMI?

Level 1 Part A

PART A #3 KEY POINTS FOR POSITIVE ANSWER

- Psychoactive medication (i.e. antipsychotic, antidepressant, and antianxiety drugs)
- Currently administered on a regular basis or was previously taking it on a regular basis within the past 2 years
- Prescribed to treat behavioral/mental health symptoms in the absence of a neurological disorder

Level 1 Part B

PART B: INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITIES (ID/DD):

1. The individual has a diagnosis of **ID** or has a history indicating the presence of **ID prior** to age 18.
2. The individual has a diagnosis of **DD/related condition** (evidence/affects intellectual functioning, adaptive functioning; autism, epilepsy, blindness, cerebral palsy, closed head injury, deaf) or has a (history indicating the presence of **DD prior** to age 22. Age of diagnosis/presence:____

Level 1 Part B

Developmental Disabilities prior age 22

- Broader category of disabilities- intellectual, physical, or both
- Examples (but not limited to): Cerebral Palsy, Down Syndrome, Autism, hearing loss, vision impairment, etc.

Intellectual Disabilities prior age 18

- Characterized by limited intellectual functioning and adaptive behavior
- Examples (but not limited to): Developmental Delay, Cognitive Disability, Down Syndrome, Autism, etc.

Related Condition prior age 22

- Closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior. The person would require similar treatment or services.
- Example (but not limited to): Closed head injury, Epilepsy, etc.

Level 1 Part B

PART B #1 and #2 KEY POINTS FOR POSITIVE ANSWER

- Likely to continue indefinitely
- Results in substantial functional limitations in three or more areas of major life activities (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently)

Level 1 Part B

PART B (cont.)

3. Does the ID/DD individual have a primary diagnosis or presence of **Dementia**? If yes, include evidence/presence of Dementia work-up, comprehensive mental status exam, if available.
4. The individual has functional limitations relating to **ID/DD** (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently).
5. The individual received/receives **ID/DD** services from an agency serving individuals with ID/DD past and/or present; referred/referrals). Describe past AND present receipt of services and referrals made from agencies that serve individuals with ID/DD:_____

If questions 1 and 2 are "No," you do not need to answer questions 3, 4, and 5

Level 1 Part C: Categorical Determinations

PART C

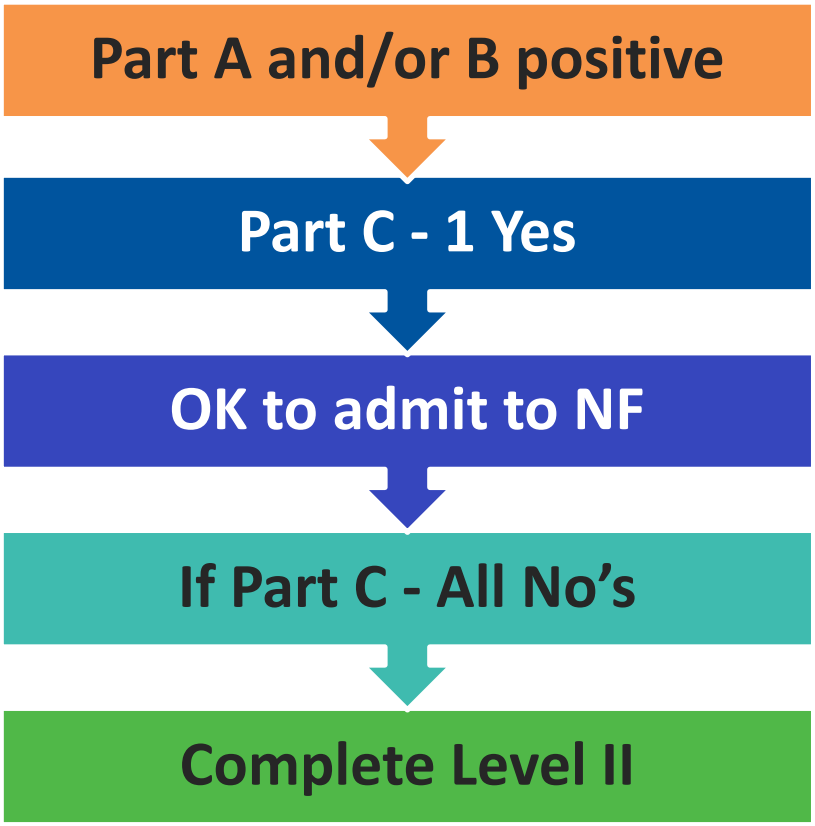
1. Is this individual being discharged from an acute care hospital and admitted to the NF for recovery from an illness or surgery **not to exceed 120 days** and is not considered a danger to self and/or others?
2. Is this individual certified by his physician to be terminally ill **(prognosis of a life expectancy of 6 months or less),** serviced by a certified, licensed hospice agency at the time of admission and is not considered a danger to self and/or others?
3. Is this individual comatose, ventilator dependent, functioning at the brain stem level or diagnosed as having a **severe physical illness**, such as, COPD, Parkinson's Disease, Huntington's Chorea, or amyotrophic lateral sclerosis; which result in a level of impairment so severe that the person cannot be expected to benefit from specialized services?

Level 1 Part C: Categorical Determinations

PART C (cont.)

4. Does this individual require provisional **admission pending** further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears?
5. Does this individual require **provisional admission which is not to exceed 7 days**, for further assessment in emergency situations that require protective services?
6. Does this individual require admission for a **brief stay of 30 days for respite care**? The individual is expected to return to the same caregivers following this brief NF stay.

Level 1 Part C: Categorical Determinations



- Ensure only one selected
- Ensure that the definition meets the individual's current status
- Monitor expiration dates or when rehab or hospice ends
- Level 2 is required on or before the expiration date or when rehabilitation or hospice ends (exemption #1 and #2)

Level 2 Evaluations

Level II Requirements

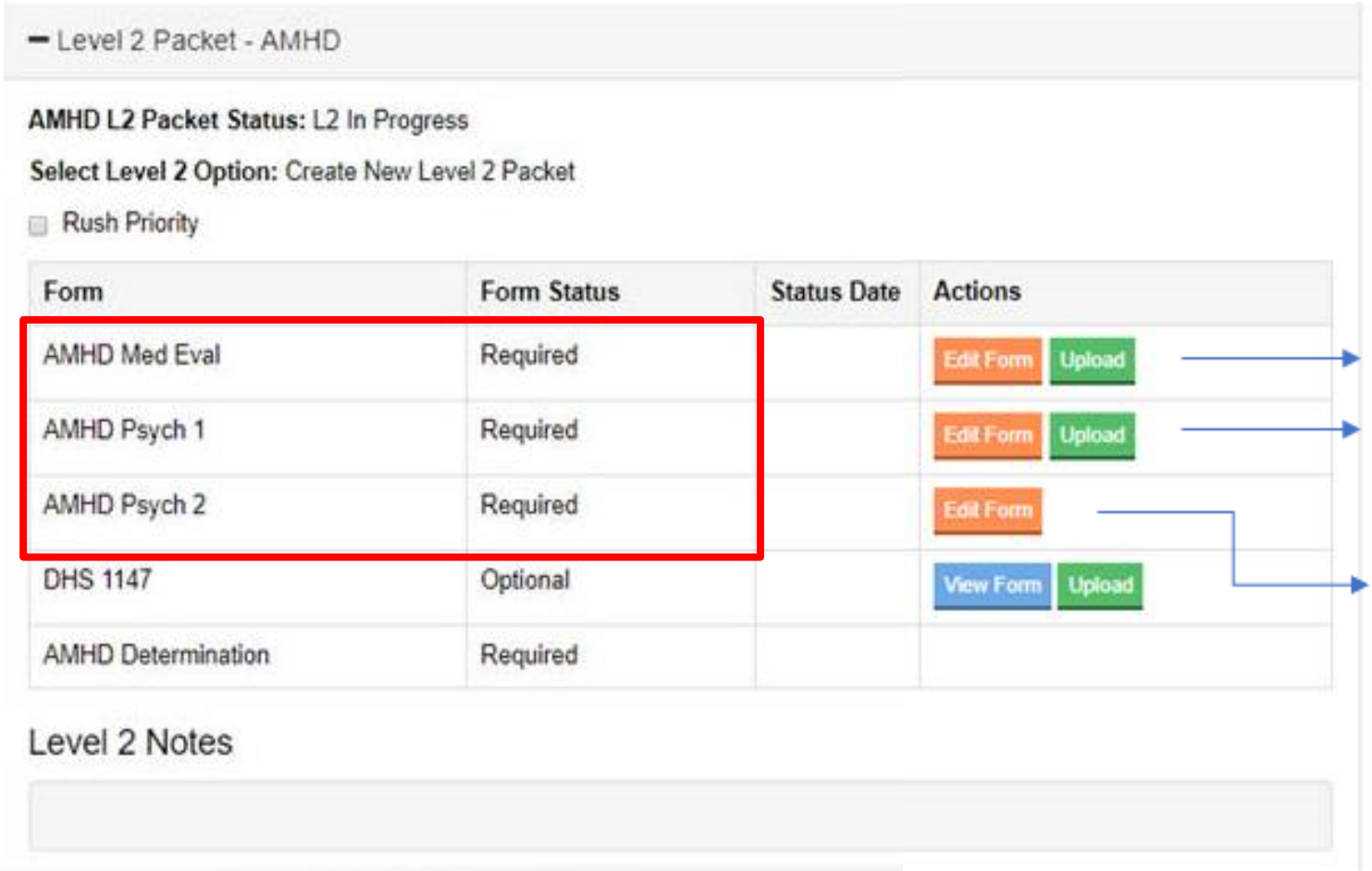
- ✓ Complete Level II prior NF admission, if Part A and/or B is positive and there is no Part C selected
- ✓ Previous Level II acceptable if still applicable to patient's condition
- ✓ Complete Level II if exemption ends or expires
- ✓ Ensure AMHD or DDD determination is completed (if required)

AMHD: Adult Mental Health Division
DDD: Developmental Disabilities Division

Level 2 Evaluations for Serious Mental Illness Forms

Level 2 Evaluations—SMI

PASRR Level 1 Part A was positive for SMI ⟶ Do AMHD Level 2 for SMI



Upload forms and be sure to click **"Complete Form"**

Complete the Psych 2 and be sure to click **"Complete Form"**

AMHD: Adult Mental Health Division
SMI: Serious mental illness

State of Hawaii
Department of Health

Behavioral Health Administration
Adult Mental Health Division

Pre-Admission Screening / Resident Review
Medical Evaluation for Persons with Mental Illness

_____ _____ ___/___/___ ___
(Last Name) (First Name) (Middle) (Medicaid ID Number if applicable) (Birthdate) (Sex)

_____ _____ _____ _____
(Home Address if applicable) (City) (State) (Zip)

Your patient's medical and psychiatric diagnosis and/or treatment regime may necessitate a determination to be made by the Department of Heath/Adult Mental Health Division regarding your need for nursing facility placement and psychiatric "active specialized treatment". A complete medical and psychiatric evaluation is needed to make this determination.

LICENSED PHYSICIAN: Please complete all subsequent items on this form or enclose copy of a recent medical history/physical record.

SIGNIFICANT HISTORY AND MAJOR ILLNESSES			
Diagnosis/Illness/Problem	Date of Treatment	Medication and Treatment	Prognosis

Does the patient have any medication allergies? ___ Yes ___ No. If yes, list allergies:

Medication and Allergic Reaction	
Medication	Reaction

Is patient currently receiving psychoactive medication? __ Yes __ No. If yes, list the drug, reason, potential side effects and date.

Name of Psychoactive Medication	Reason Drug is Prescribed	Start Date	Side Effects

What is this patient's ability to perform ADLs in the community and describe the level of support needed to perform activities in the community:

Physical Exam: Weight _____ Height _____ Temperature _____ Pulse _____ Blood Pressure _____

Normal	Check each item in the appropriate Column. Enter "NE" if not evaluated	Abnormal	Findings
	Head, Face, Neck, and Scalp		
	Nose, Throat, and Mouth		
	Sinuses		
	Ears, General		
	Hearing: Right ____ Left ____		
	Ophthalmoscopic		
	Pupils		
	Vision: Far _____ Near _____		
	Lungs and Chest		
	Heart		
	Vascular System		
	Abdomen and Viscera		
	Anus and Rectum		
	Endocrine System		
	G-U System		
	Upper Extremities		
	Lower Extremities		
	Feet		
	Spine, Other Musculoskeletal		
	Identifying Body Marks, Tatoos, Scars		
	Skin, Lymphatics		
	NEUROLOGICAL		
	Motor (station, gait, power, coordination)		
	Sensory (pain, temperature, touch, deep pain and vibratory sense)		
	Reflexes (superficial)		
	(deep)		
	(pathological)		
	Cranial Nerves:		
	I		
	II		
	III, IV, VI		
	V		
	VII		
	VIII		
	IX, X, XI		

Level of Care SNF _____ ICF _____ HOSPICE _____ DEFERRED _____ OTHER (Specify) _____
Physical Diagnosis:_____

_____ MD _____ MD _____
Examining Physician (Print or Type) Signature of Physician Date

SMI—Medical Evaluation or H&P

State of Hawaii
Department of Health

Behavioral Health Administration
Adult Mental Health Division

Pre-Admission Screening / Resident Review
Psychiatric Evaluation Part I

_____ _____ ___/___/___ ____ ___
(Last Name) (First Name) (Middle) (Medicaid ID Number, if applicable) (Birthdate) (Age) (Sex)

_____ _____ _____ _____
(Home Address if applicable) City) (State) (Zip)

The psychiatric evaluation consists of two forms including: PSYCHIATRIC EVAUATION, PART I AND PART II: SERIOUS MENTAL ILLNESS CRITERIA. All forms must be completed. Please provide sufficient information to determine the patient's need for "active treatment/specialized services". Use the back of Part II form if additional space is needed to record your response.

1. Psychiatric History (including Drug History): Provide dates if known.

2. Current Psychiatric Condition:
   a. Is the patient a harm to self or others, i.e. suicidal or homicidal ideation, and/or exhibit externalizing and/or internalizing behaviors, i.e. physical violence, damage to property, sexually inappropriate, self abusive, or abuses unauthorized substances?

   b. Is patient delusional and/or has hallucinations?

3. Mental Status (appearance, orientation, affect and mood, thought, insight, organicity, etc.):

4. Describe Patient's Strengths and Weaknesses:

5. Estimated IQ Level:

6. Psychosocial Evaluation: Include current living arrangements, medical and support systems:

7. Recommendations / Plans of Service / Appropriate Placement:

8. Diagnosis: (A listing of applicable diagnoses is available on back of this form)

DSM – III – R	Axis I	Axis II	Axis IV	Axis V
Primary				

_____ _____ _____
Psychiatrist/Psychologist Name and Title Signature Date

AMHD/PASRR FORM 3 (01/26/18)

SMI—Psychiatric Evaluation, Part I

State of Hawaii
Department of Health

Behavioral Health Administration
Adult Mental Health Division

Pre-Admission Screening / Resident Review
PSYCHIATRIC EVALAUTION PART II
SERIOUS MENTAL ILLNESS (SMI) CRITERIA

_____ ____/____/____
(Last Name) (First Name) (Middle Initial) Birthdate

An individual is considered to have a serious mental illness (SMI) if the individual meets the following requirements on diagnosis, level of impairment, and duration of illness:

1. DIAGNOSIS
The patient is 18 years or older and has a possible diagnosis within the following DSM-III-R disorders: "a schizophrenic, mood, paranoid, panic or other severe anxiety disorder, somatoform disorder personality disorder, other psychotic disorder, or another mental disorder that may lead to a chronic disability." (See Part I or Psychiatric Evaluation) ___YES ___NO

2. LEVEL OF FUNCTIONAL IMPAIRMENT
On a continuing or intermittent basis for the past 3 to 6 months, the patient's mental disorder has resulted in one or more functional limitations in major life activities characterized by:

a. Problems in interpersonal functioning: ___YES ___NO
- Has serious difficulty interacting appropriately and communicating effectively; or
- Has a history of altercations, evictions, being fired from a job, fear of strangers, avoidance of interpersonal relationships and social isolation.

b. Problems in concentration, persistence and pace: ___YES ___NO
- Has serious difficulty in sustaining attention to permit completion of tasks in work or work like settings, or in school and home settings; or
- Manifests difficulties in concentration; or
- Unable to complete simple tasks within an established time period, makes frequent errors or requires assistance in completing simple tasks.

c. Problems in adaptation to change: ___YES ___NO
- Has serious difficulty in adapting to changes associated with work, school, family or social interaction; or
- Requires mental health or judicial interventions due to exacerbated signs and symptoms associated with the illness or withdrawal from the situation.

3. RECENT TREATMENT OR HISTORY INDICATES THE INDIVIDUAL HAS EXPERIENCED AT LEAST ONE OF THE FOLLOWING IN THE LAST TWO YEARS.
a. Psychiatric treatment more intensive than outpatient care more than once; or ___YES ___NO
b. Required supportive services to maintain functioning at home or in a residential treatment environment; or ___YES ___NO
c. Required intervention by housing or law enforcement officials. ___YES ___NO

IS THE INDIVIDUAL SERIOUSLY MENTALLY ILL (SMI)? ____ YES ____ NO
An individual is considered to be seriously mentally ill if the following criteria are met: Yes to diagnostic classification; Yes to either 2a or 2b or 2c AND Yes to either 3a, 3b, or 3c.

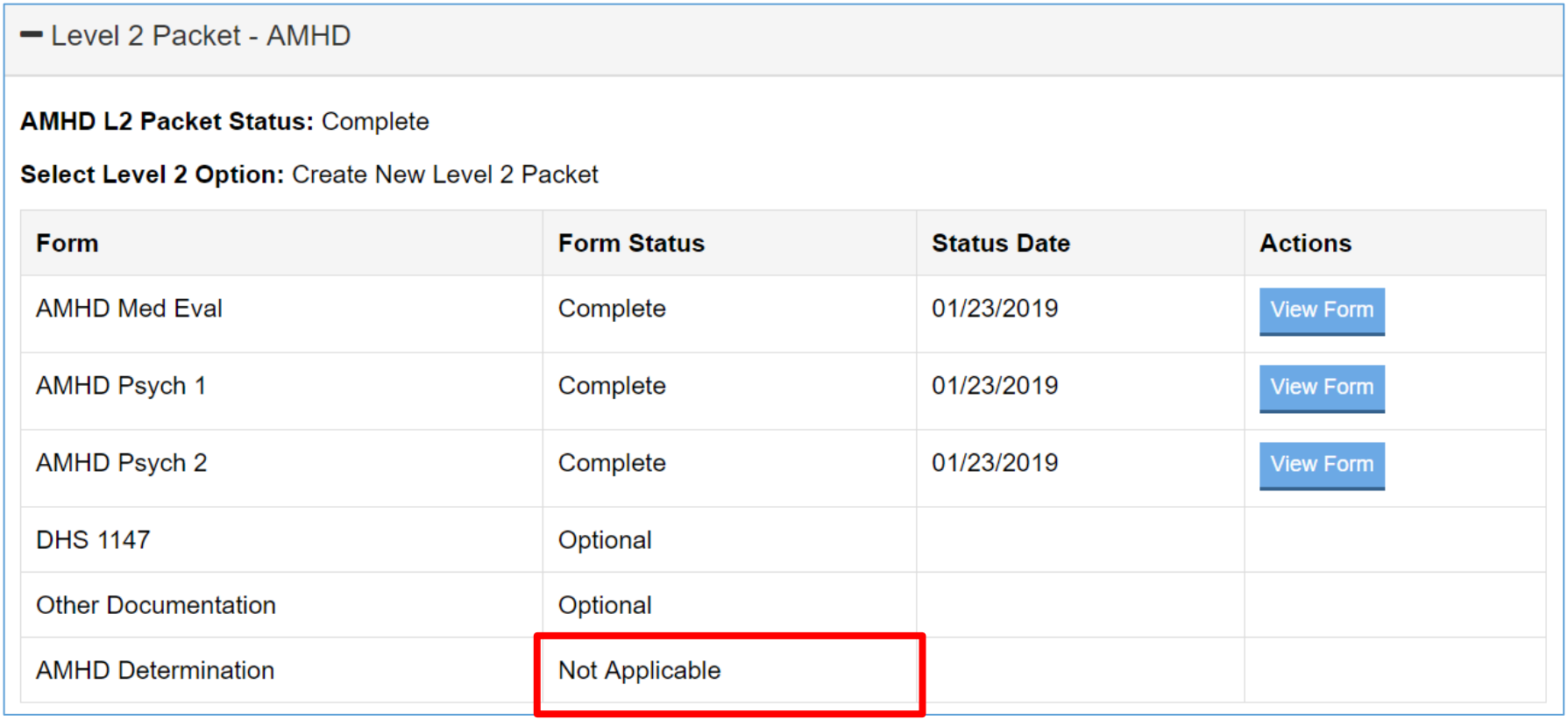
AMHD/PASRR FORM 4 (08/01/12)

If found NOT SMI on form 4, determination from AMHD is NOT required

SMI— Psychiatric Evaluation, Part II

Psych Eval Part 2 (continued)

If marked "No" for "Is the Individual Seriously Mentally Ill (SMI)", Determination is not needed and in ePASRR, AMHD Determination will change to "Not Applicable."



Level 2 Packet - AMHD

AMHD L2 Packet Status: Complete

Select Level 2 Option: Create New Level 2 Packet

Form	Form Status	Status Date	Actions
AMHD Med Eval	Complete	01/23/2019	View Form
AMHD Psych 1	Complete	01/23/2019	View Form
AMHD Psych 2	Complete	01/23/2019	View Form
DHS 1147	Optional		
Other Documentation	Optional		
AMHD Determination	Not Applicable		

DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, MD
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
Adult Mental Health Division
P.O. Box 3378
Honolulu, HI 96801-3378

DATE

PATIENT NAME
PATIENT ADDRESS

Dear <<Patient FNAME LNAME>>

The Nursing Home Reform Provisions of the Omnibus Budget Reconciliation Act (OBRA) passed by Congress in December 1987 and amended January 1993 require that any person with the diagnosis of mental illness or related condition be screened to determine that the nursing facility is the appropriate placement for the individual. This letter is a report of this routine procedure that is completed to assure you are receiving the level of mental care you need.

Using criteria established for this purpose by the Centers for Medicare and Medicaid Services (CMS), the Adult Mental Health Division has determined that you are <<insert determination here>>.

P.L. 104-315 (October 1996) amended the annual resident review provisions to require nursing facilities to promptly notify us only if there is a significant change in the resident's physical or mental condition. We will then complete a resident review after notification by the facility. Thus, a resident review will be completed upon notification by the facility of any significant changes in your condition.

If you do not agree with this decision, you have a right to request an informal review or submit a written request for a fair hearing. The request must be submitted to our department within ninety (90) days of receipt of this notice. You may appeal this decision independently or be represented by an authorized representative, such as a legal counsel, relative, friend, or any other person of your choice.

If you have any questions, please call 453-6922.

Sincerely,

Michael Champion M.D.
AMHD Psychiatry Chief
Adult Mental Health Division

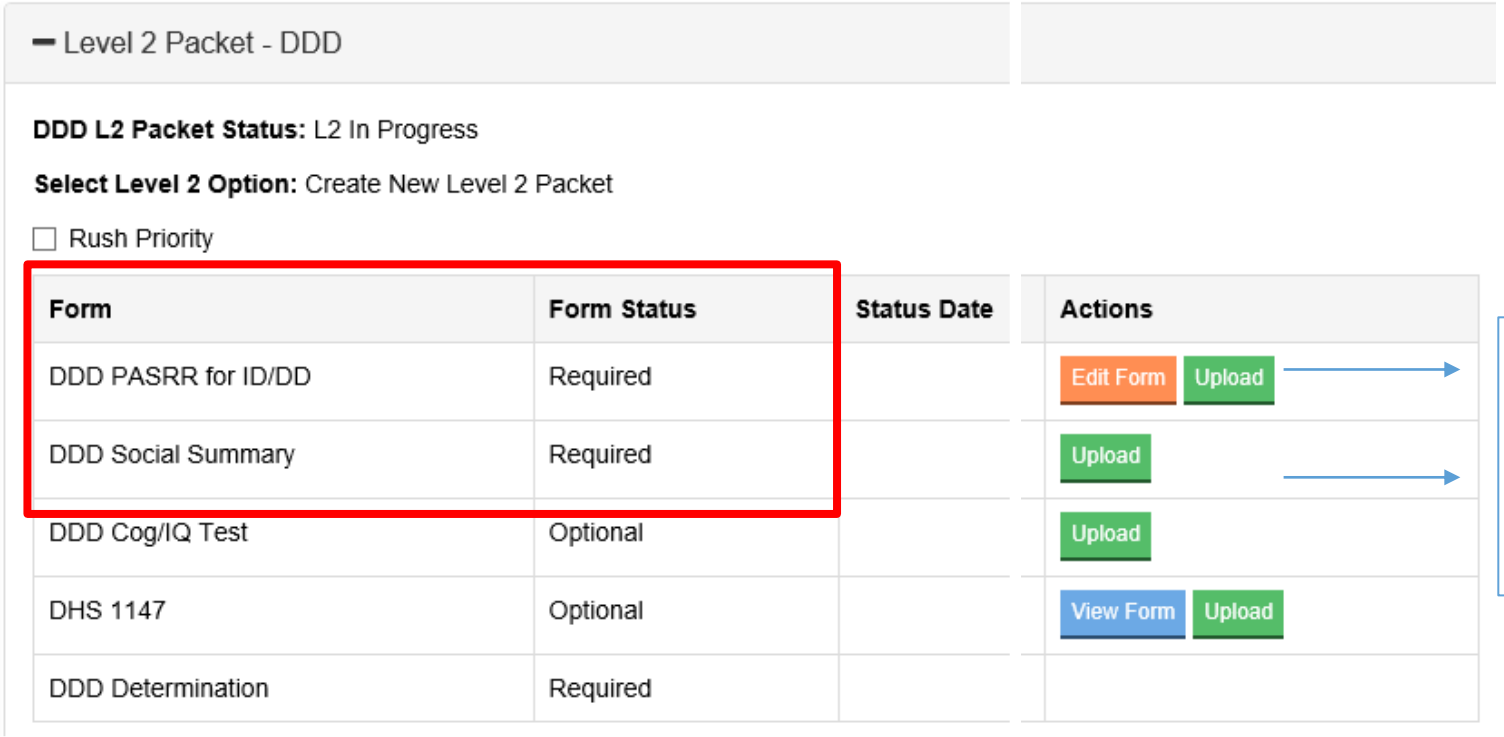
AMHD Determination Letter

Level 2 Evaluations for ID/DD/RC Forms

Level 2 Evaluations—ID/DD/RC

PASRR Level 1 Part B was positive for ID/DD/RC ➞ Do DDD Level 2

- ✓ PASRR for Persons with ID/DD/RC form
- ✓ Social Summary



Upload forms and be sure to click "**Complete Form**"

ID/DD/RC: Intellectual Disability/Developmental Disabilities & Related Condition
DDD: Developmental Disabilities Division

Preadmission Screening and Resident Review (PASRR)
For Persons With Intellectual Disability/Developmental Disabilities and Related Conditions
Hawaii State Department of Health
Developmental Disabilities Division

I. _____ _____ _____ _____ _____
Patient Last Name | First Name | MI | Sex | Medicaid #

_____
Present Address

Range (Check One):

II. DIAGNOSIS: Intellectual Disability (ID) IQ Score: _____ Mild ☐ Mod ☐ Severe ☐ Profound ☐

Other Diagnosis/Illness/Problem	Date of Onset	Current Medication/Dosage	Prognosis/Impact on Functioning

III. PHYSICAL EXAMINATION: Weight: _____ Height: _____ BP: _____

Check each item in appropriate column (normal/abnormal). Enter "NE" if not evaluated. Attach any pertinent reports.

Category	Normal	Abnormal	Description of Abnormal Conditions
Head, Face, Neck, and Scalp	☐	☐	
Nose, Throat and Mouth, Sinuses	☐	☐	
Ears – General	☐	☐	
Hearing: Right: Left:	☐	☐	
Eyes – General	☐	☐	
Vision: Right: Left:	☐	☐	
Heart and Vascular System	☐	☐	
Lungs and Chest	☐	☐	
Genitourinary System	☐	☐	
Abdomen and Viscera	☐	☐	
Anus and Rectum	☐	☐	
Endocrine System	☐	☐	
Upper Extremities	☐	☐	
Lower Extremities	☐	☐	
Spine, Other Musculoskeletal	☐	☐	
Skin, Lymphatic System	☐	☐	
Neurological System	☐	☐	
Psychiatric	☐	☐	

IV. FUNCTIONAL ASSESSMENT (to be completed by professional who knows the patient/resident best): First assess person's functional level as either independent or dependent/requiring partial assist compared to others in the age group. If the person is dependent/partial assist, then determine whether the person needs and/or may benefit from training (as opposed to short term therapy) – i.e. working in a step-wise manner to achieve/maintain goals(s) for independence using specialized techniques generally used for educating/training persons with developmental disabilities/intellectual disabilities.

	INDEPENDENT	DEPENDENT OR REQUIRING PARTIAL ASSIST MAY BENEFIT FROM TRAINING? YES	NO
SELF-CARE/PERSONAL CARE:	☐	☐	☐
Able to perform necessary steps involved in bowel/bladder elimination	☐	☐	☐
Able to dress and undress self	☐	☐	☐
Able to groom and complete personal hygiene needs as bathing, brushing teeth	☐	☐	☐
Able to drink fluids, chew, and swallow foods and use utensils to feed self	☐	☐	☐
COMMUNICATION:	☐	☐	☐
Able to understand and follow simple directions	☐	☐	☐
Able to communicate one's basic needs and wants	☐	☐	☐
Can verbally communicate	☐	☐	☐
Is non-verbal – uses gestures and some single words	☐	☐	☐
COGNITIVE/SOCIAL:	☐	☐	☐
Able to retain and recall what has been learned or experienced	☐	☐	☐
Able to respond appropriately to visual or auditory stimuli	☐	☐	☐
Able to make choices with little or no direction from others	☐	☐	☐
Able to choose, initiate, and engage in leisure activities	☐	☐	☐
Able to evaluate, use logic to discriminate/generalize situations and viable solutions	☐	☐	☐
Able to discriminate gender similarities/differences and appropriate social/sexual behaviors	☐	☐	☐
Able to relate to others on a 1:1 or group basis	☐	☐	☐
MOTOR ABILITIES/MOBILITY:	☐	☐	☐
Able to perform coordinated gross motor activities	☐	☐	☐
Able to perform coordinated fine motor activities	☐	☐	☐
Able to perform eye-hand coordinated activities	☐	☐	☐
Able to independently use available transportation to get to desired destination	☐	☐	☐
Able to independently move from place to place in a wheelchair	☐	☐	☐
VOCATIONAL:	☐	☐	☐
Able to adapt to changes in job related situations (peers, supervisors, assignments)	☐	☐	☐
Able to demonstrate appropriate and acceptable job specific skills	☐	☐	☐
Able to demonstrate responsible work related behaviors as attendance, work on time	☐	☐	☐
INDEPENDENT LIVING SKILLS:	☐	☐	☐
Able to perform independent living household activities as budgeting, shopping	☐	☐	☐
Able to monitor own health status	☐	☐	☐
Able to administer own medications	☐	☐	☐
Able to schedule medical appointments and follow-up	☐	☐	☐
Able to monitor own nutritional status, including making meals	☐	☐	☐

NEEDS ADAPTIVE DEVICES TO PERFORM ANY/ALL OF THE ABOVE: SPECIFY
(e.g. prosthesis, orthosis, hearing aid, visual aid, communication device)

V. EXERNALIZING AND INTERNALIZING BEHAVIORS(S):	FREQUENCY (specify day/week/mo.)	MILD	MOD	SEVERE
Physical violence against others		☐	☐	☐
Damage to property		☐	☐	☐
Sexually inappropriate		☐	☐	☐
Self-abusive		☐	☐	☐
Abuse of unauthorized substances		☐	☐	☐
Other:		☐	☐	☐
Other:		☐	☐	☐
Other:		☐	☐	☐

VI. PSYCHOSOCIAL EVALUATION: Current living arrangements, medical and support system

_____ _____ _____
Name of Examining Physician | Signature of Physician | Date

DDD PASRR for ID/DD/RC form

DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, MD
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
Developmental Disabilities Division
3627 Kilauea Avenue, Room 109
Honolulu, HI 96816
Telephone: (808) 733-9177
Fax: (808) 733-9182

DATE

PATIENT NAME
PATIENT ADDRESS

Dear <<Patient FNAME LNAME>>

As the State's Intellectual/Developmental Disabilities authority, the Department of Health's Developmental Disabilities Division (DDD) completes for individuals with intellectual disability and related conditions the initial screening and resident reviews for appropriateness of nursing facility placement required under the Nursing Home Reform Provisions of the Omnibus Budget Reconciliation Act of 1987.

Using criteria established for this purpose by the Centers for Medicare and Medicaid Services, the Developmental Disabilities Division has determined that you are <<insert determination here>>.

P.L. 104-315 (October 1996) amended the annual resident review provisions to require nursing facilities to promptly notify us only if there is a significant change in the resident's physical or mental condition. We will then complete a resident review after notification by the facility. Thus, a resident review will be completed upon notification by the facility of any significant changes in your condition.

If you do not agree with this decision, you have a right to request an informal review or submit a written request for a fair hearing. The request must be submitted to our department within (ninety) 90 days of receipt of this notice. You may appeal this decision independently or be represented by an authorized representative, such as a legal counsel, relative, friend, or any other person of your choice.

If you have any questions, please call 733-9177.

Sincerely,

Stephanie Guieb, RN, MSN
Clinical Eligibility Determination Staff
Developmental Disabilities Division

DDD Determination Letter

Level 2 – AMHD/DDD Determinations

1. If Determination is required - AMHD and/or DDD will receive an email notification to review the case. Packet will switch to “Pending Level 2 Determination”
2. If AMHD and/or DDD has questions or needs additional information – They will enter a note in ePASRR and defer the case. Packet will switch to “Level 2 Deferred”
3. Facility will need to address the deferral then click the “Complete Level 2” button to send it back to AMHD or DDD
4. Once the Determination is complete, the letter will be available to view and print

Resident Review Process

Resident Review Process – NF Only

Resident Review required for patients:

- Who show a significant change that
  - Results in a newly suspected diagnosis of a mental illness or ID/DD **or**
  - Individual's condition warrants review for specialized services
    - Use of a psychiatric or psychological consultation to effectively treat/care for behavioral changes
    - Initial prescription or change in prescription of psychoactive medication to treat behavioral changes
    - An update or revision of patient's care plan to address behavioral changes or worsening of condition

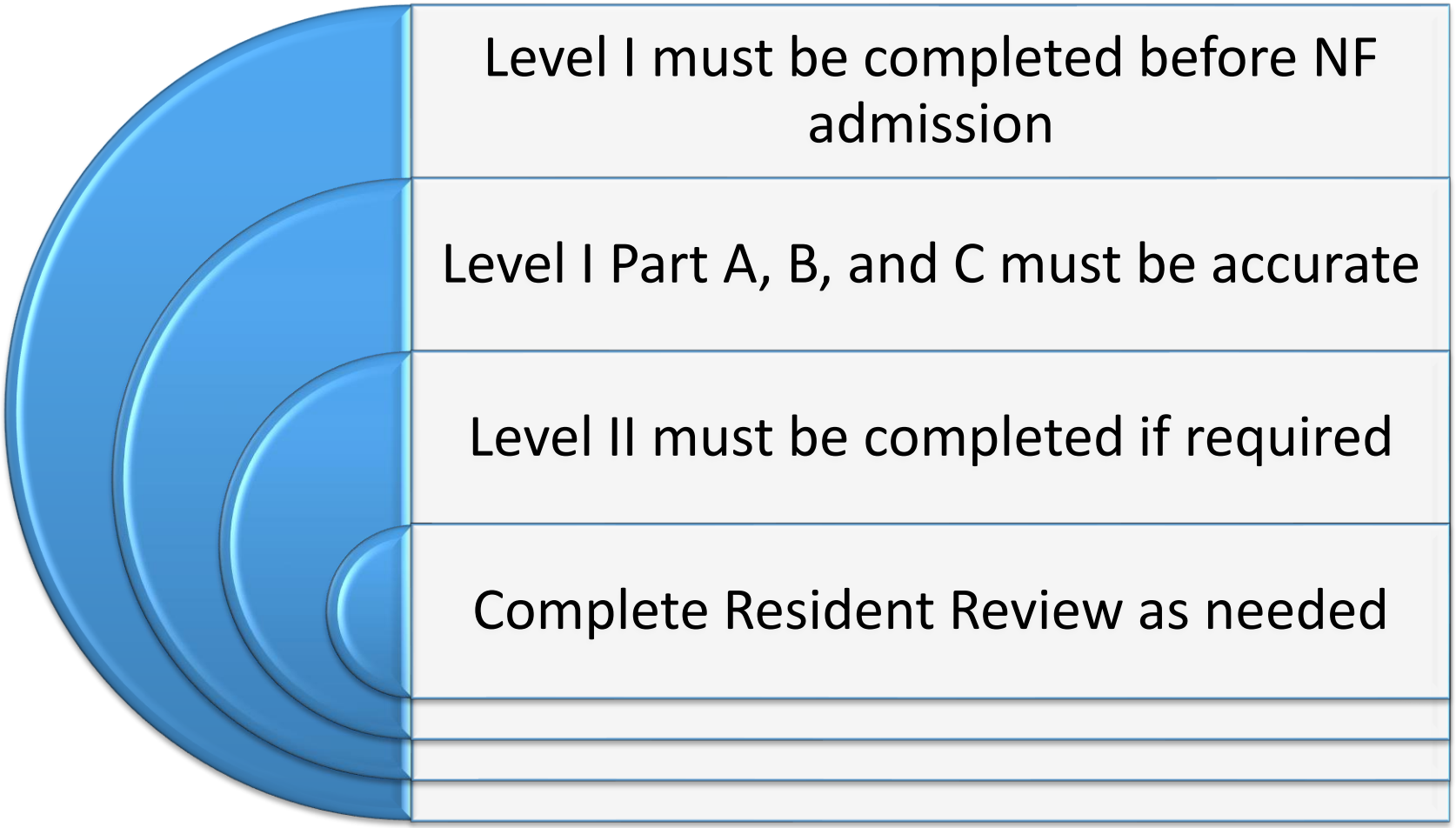
Resident Review Process

Resident Review Requirements

- Care Plan reassessment by **seventh** day
- Comprehensive assessment by **fourteenth** day
- Complete a Level 2 by **twenty-first** day if individual's condition warrants review for specialized services

➢ Begin treatment, attempt to stabilize a resident, develop a revised care plan, and determine whether changes in a patient's condition warrants a Level II or review for specialized services

Recap PASRR Requirements



Quarterly PASRR Compliance Reviews (Audits)

Compliance Reviews

Process:

- HSAG performs compliance reviews every quarter
- Sample is generated from nursing facilities' census reports submitted in ePASRR
- Nursing facilities provide medical records in ePASRR for their sample

Compliance Reviews

Reasons for Non-Compliance:

- Late or missing Level I
- Inaccurate Level I Part A, B, or C
- Level I not completed by MD, APRN, Hospital D/C RN
- Late or missing Level II
- Level II for SMI not completed by psychiatrist or psychologist
- No Determination
- Missing Resident Review

PASRR Non-Compliant Cases Actions:

- Med-QUEST will be notified
- Corrective Action Plans will be required by the NF
- Potential recoupment for all daily per diem if Medicaid is the primary payor
- Tracking and trending
- Potential increase in sampling

Responsibilities of Facilities

Responsibilities of Facilities

Hospital Facilities/Referring Entities

- Ensure Level 1 is completed and entered in ePASRR accurately according to the patient's condition, past medical history, and medications
- Ensure to create or copy PASRR packet for all admission and readmissions to NF
  - A previous Level I maybe used for a re-admission to the nursing facility; however, it needs to be initiated in ePASRR as a new packet (select copy existing Level I)
- Complete Level 2 when required
- Obtain AMHD and/or DDD determination when required
  - Provide the determination letter to the patient and physician
- Assign the PASRR packet to the nursing facility and complete the packet

Responsibilities of Facilities

Nursing Facilities

Prior admission/readmission:

- Ensure PASRR is done ***prior*** all admissions and re-admissions and entered in ePASRR.
  - A previous Level I maybe used for a re-admission; however, it needs to be initiated in ePASRR as a new packet
- Review PASRR Part A & B for accuracy. If Part C completed, be sure it's correct.
- Ensure PASRR Level I is done by appropriate healthcare provider: MD, APRN, Hospital Discharge RN (no RNs outside hospital may complete the Level I)
- Have hospital/referring entities make corrections before accepting the patient.

Responsibilities of Facilities

Nursing Facilities

Prior admission/readmission (cont.):

- Ensure Level II (if required) is completed and entered in ePASRR. If determination is required by AMHD and/or DDD prior admission, be sure it's completed and available in ePASRR.
  - Psychiatric Evaluations must be done by a psychiatrist or psychologist
- If determination completed by AMHD and/or DDD, be sure it states nursing facility is appropriate and no specialized services is required and provide a copy to the patient and physician.
- Ensure your nursing facility is selected as placement and packet status is complete
- Enter PASRR for community admissions (there is a community admission selection in ePASRR).

Responsibilities of Facilities

Nursing Facilities

While in Nursing Facility:

- Monitor the patients with positive PASRR Level I and categorical determinations (Part C, exemptions) selected.
  - Level 2 is required on or before the expiration date or when rehabilitation or hospice ends (exemption #1 and #2), which ever comes first
- Monitor for any significant change in the patient that may require resident review. Follow resident review process.
- Complete monthly census in ePASRR.
- Provide medical records for quarterly PASRR compliance review.

ePASRR—Training Resources

- Refer to **ePASRR Frequently Asked Questions (FAQs)**

  Step-by-step instructions on below:

  - Registration
  - Login
  - Creating/copying Level 1
  - Completing Level 2
  - Assigning placement
  - Community admission
  - Transfers to another NF

- Refer to **ePASRR training videos**

Found on HSAG website: www.hsag.com/myhawaiieqro

HSAG Contacts

Health Services Advisory Group (HSAG)

Desire Mizuno, Nurse Reviewer/Manager: dmizuno@hsag.com

Erika Shigemasa, Nurse Reviewer: eshigemasa@hsag.com

Susan Mora, Project Coordinator (user accounts): smora@hsag.com

Website: www.hsag.com/myhawaiieqro

Technical Assistance:

ePASRR: ePASRRSupport@hsag.com

HSAG Hawaii Office: 808.941.1444

Fax: 808.941.5333

(office hours 7:45 A.M. – 4:30 P.M. HST)

HSAG Help Desk (after hours):

1.866.316.6974

Contacts

Med-QUEST
Kathy Ishihara, Nurse Consultant:
kishihara@dhs.hawaii.gov
Phone: 808.692.8159

Developmental Disabilities Division
Stephanie Guieb, RN: stephanie.k.guieb@doh.hawaii.gov
Phone: 808.733.9177

Adult Mental Health Division
LaVerne Webb, RN: laverne.webb@doh.hawaii.gov
Phone: 808.453.6954

Jocelyn Nazareno, Clerk jocelyn.nazareno@doh.hawaii.gov
Phone: 808.453.6968

Questions?

Thank you!


thank you
danke
gracias
merci
obrigado
謝謝
teşekkür ederim
ngiyabonga
спасибо
dziękuję
bedankt
sukriya
kop khun krap
go raibh maith agat
mochchakkeram
arigatô
dakujem
grazie
terima kasih
감사합니다
мерси
dank je
tapadh leat
ευχαριστώ

Documents attached:

DHS PASRR Level I Screen

PASRR Applicable DSM-III-R Diagnoses

DOH Adult Mental Health Division Level II:

- Medical Evaluation for Persons with Mental Illness
- Psychiatric Evaluation Part I
- Psychiatric Evaluation Part II

DOH Developmental Disabilities Division Level II:

- PASRR for Persons with Intellectual Disability/Developmental Disabilities and Related Conditions

Documents also available:

ePASRR Resources and Instructions and

HSAG website:
https://www.hsag.com/en/myhawaiieqro/pasrr/

STATE OF HAWAII **Med-QUEST Division**

Department of Human Services

PREADMISSION SCREENING RESIDENT REVIEW (PAS/RR) **LEVEL I SCREEN**	**PATIENT'S NAME: (Last Name, First, M.I.)**	**DATE OF BIRTH: (MM/DD/YY)**
	PRIMARY DIAGNOSIS:	**MEDICAID I.D. NUMBER:**
	REFERRAL SOURCE: (Physician's Name; Nursing Facility; Hospital; Etc.)	

PART A: SERIOUS MENTAL ILLNESS (SMI): **YES** **NO**

1. The individual has symptom(s) and/or a current diagnosis of a Major Mental disorder and/or a Substance Related disorder, which seriously affects interpersonal functioning (difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others), and/or completing tasks (difficulty completing tasks, required assistance with tasks, errors with tasks; concentration; persistence; pace), and/or adapting to change (self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, withdrawal): ( ) ( )
   a. A **SCHIZOPHRENIC** disorder, **MOOD** disorder, **DELUSIONAL (PARANOID)** disorder, **PANIC OR OTHER SEVERE ANXIETY** disorder, **SOMATOFORM** disorder, **PERSONALITY** disorder, **SUBSTANCE RELATED** disorder or **PSYCHOTIC** disorder not elsewhere classified that may lead to a chronic disability; **BUT**
   b. **NOT** a primary or secondary diagnosis of **DEMENTIA**, including **ALZHEIMER'S DISEASE OR A RELATED DISORDER.**
2. Does the SMI individual have Dementia? If yes, include evidence/presence of workup, comprehensive mental status exam. ( ) ( )
3. Has psychoactive drug(s) been prescribed on a regular basis to treat behavioral/mental health symptom(s) for the individual within the last two (2) years with or without current diagnosis of SMI? ( ) ( )

PART B: INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITIES (ID/DD): **YES** **NO**

1. The individual has a diagnosis of **ID** or has a history indicating the presence of **ID prior** to age 18. ( ) ( )
2. The individual has a diagnosis of **DD/related condition** (evidence/affects intellectual functioning, adaptive functioning; autism, epilepsy, blindness, cerebral palsy, closed head injury, deaf) or has a history indicating the presence of **DD prior** to age 22. Age of diagnosis/presence: ____ ( ) ( )
3. Does the ID/DD individual have a primary diagnosis or presence of **Dementia**? If yes, include evidence/presence of Dementia work-up, comprehensive mental status exam, if available. ( ) ( )
4. The individual has functional limitations relating to **ID/DD** (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently). ( ) ( )
5. The individual received/receives **ID/DD** services from an agency serving individuals with ID/DD; (past and/or present; referred/referrals). Describe past AND present receipt of services and referrals made from agencies that serve individuals with ID/DD. _____ ( ) ( )

_____

DETERMINATION:

1. If any of the answers in Parts A or B are **YES, COMPLETE PART C (page 2)** of this form.
2. If all of the answers in Parts A or B are **NO, SIGN** and **DATE** BELOW:

LEVEL I SCREEN IS NEGATIVE FOR SMI OR ID/DD
THE PATIENT MAY BE ADMITTED TO THE NF:

DATE AND TIME COMPLETED:

_____ _____

SIGNATURE OF PHYSICIAN, APRN, HOSPITAL DC PLANNER RN **MM/DD/YY**

_____ _____

PRINT NAME **Time**

PART C:		**YES**	**NO**
1.	Is this individual being discharged from an acute care hospital and admitted to the NF for recovery from an illness or surgery **not to exceed 120 days** and is not considered a danger to self and/or others?	( )	( )
2.	Is this individual **certified** by his physician to be terminally ill **(prognosis of a life expectancy of 6 months or less),** serviced by a certified, licensed hospice agency at the time of admission and is not considered a danger to self and/or others?	( )	( )
3.	Is this individual comatose, ventilator dependent, functioning at the brain stem level or diagnosed as having a **severe physical illness,** such as, COPD, Parkinson's Disease, Huntington's Chorea, or amyotrophic lateral sclerosis; which result in a level of impairment so severe that the person cannot be expected to benefit from specialized services?	( )	( )
4.	Does this individual require **provisional admission** pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears?	( )	( )
5.	Does this individual require **provisional admission which is <u>not to exceed 7 days</u>,** for further assessment in emergency situations that require protective services?	( )	( )
6.	Does this individual require admission for **a brief stay of 30 days for respite care**? <u>The individual is expected to return to the same caregivers following this brief NF stay.</u>	( )	( )

……

<u>CHECK ONLY ONE:</u>

[ ] If **any** answer to Part C is **Yes, <u>NO REFERRAL for LEVEL II</u>** <u>evaluation and determination is necessary at this time.</u> **<u>NOTE TIME CONSTRAINTS!</u>**

[ ] If **all** answers to Part C are **No, <u>REFERRAL for LEVEL II</u>** <u>evaluation and determination</u> **<u>MUST BE MADE.</u>**

SIGN and DATE this form.

	DATE & TIME COMPLETED:
SIGNATURE OF PHYSICIAN, APRN, HOSPITAL DC PLANNER RN	**MM/DD/YY**
PRINT NAME	**Time**

PASRR APPLICABLE DSM-III-R DIAGNOSES*

SCHIZOPHRENIA

Code in fifth digit: 1=subchronic, 2=chronic, 3=chronic with exacerbation, 4= in remission, 0=unspecified

295.1x disorganized
295.2x catatonic
295.3x paranoid, specify if stable
295.9x undifferentiated
295.6x residual, specify if late onset

DELUSIONAL (PARANOID) DISORDER

297.10 Delusional Paranoid Disorder. Specify ertomanic, grandose, jealous, persecutory, unspecified

PSYCHOTIC DISORDERS NOT ELSEWHERE CLASSIFIED

295.40 Schizophreniform disorder, specify without good prognosis or without good prognostic features
295.70 Schizoaffective disorder, specify bipolar or depressive type
297.30 Induced Psychotic Disorder
298.80 Brief Reactive Psychosis
298.90 Psychotic Disorder NOS (Atypical psychosis)

MOOD DISORDERS

Code current state of Major Depression and Bipolar Disorder In fifth digit:

1= mild
2= moderate
3= severe without psychotic features
4= with psychotic features (Specify mood congruent or mood incongruent)
5= in partial remission
6= in full remission
0= unspecified

For major depressive episodes, specify if chronic and specify melancholic type.

For Bipolar Disorders, Bipolar Disorders NOS, recurrent Major Depression and Depressive Disorders NOS, specify if seasonal pattern.

BIPOLAR

296.4x manic
296.5x depressive
296.6x mixed
296.70 Bipolar disorder NOS
301.13 Cyclothymia

DEPRESSIVE DISORDERS
Major Depression

296.2x single episode
296.3x recurrent
300.40 Dysthymia or depressive neurosis, specify primary or secondary, early or late onset
311.00 Depressive disorder NOS

ANXIETY DISORDERS (for Anxiety and Phobia neuroses)

Panic Disorders

300.01 Without agoraphobia specify current severity of panic attacks
300.21 With agoraphobia specify current severity of agoraphobia avoidance specify current severity of panic attacks
300.22 Agoraphobia without history of panic attacks. Specify with or without limited symptom attacks.
300.23 Social Phobia specify if generalized type
300.29 Simple Phobia
300.30 Obsessive compulsive disorder (or Obsessive compulsive neurosis)
309.89 Post traumatic stress disorder specify if delayed onset
300.00 Anxiety disorder NOS
300.02 Generalized anxiety disorder

SOMATOFORM DISORDERS

300.11 Conversion Disorder (or hysteria neurosis, conversion type)
300.701 Body dysmorphic disorder
300.702 Hypochondriasis (or Hypochondrical neurosis)
300.703 Somatoform disorder NOS
300.704 Undifferentiated somatoform disorder
307.80 Somatoform pain disorder
300.81 Somatization disorder

PERSONALITY DISORDERS (Coded on Axis II)

Cluster A
301.00 Paranoid
301.20 Schizoid
301.22 Schizotypal

Cluster B
301.50 Histronic
301.70 Antisocial
301.81 Narcissistic
303.81 Borderline

Cluster C
301.40 Obsessive/Compulsive
301.60 Dependent
301.82 Avoidant
301.84 Passive Aggressive
301.90 Personality Disorder NOS

*Federal Register Vol. 57 No. 230 11/30/92 Page 56507 (483.102)

Pre-Admission Screening / Resident Review
Medical Evaluation for Persons with Mental Illness

_____	_____	___/___/___	_____
(Last Name) (First Name) (Middle)	(Medicaid ID Number)	(Birthdate)	(Sex)
_____	_____	_____	_____
(Home Address)	(City)	(State)	(Zip)

Your patient's medical and psychiatric diagnosis and/or treatment regime may necessitate a determination to be made by the Department of Heath/Adult Mental Health Division regarding your need for nursing facility placement and psychiatric "active specialized treatment". A complete medical and psychiatric evaluation is needed to make this determination.

LICENSED PHYSICIAN: Please complete all subsequent items on this form or enclose copy of a recent medical history/physical record.

SIGNIFICANT HISTORY AND MAJOR ILLNESSESS			
Diagnosis/Illness/Problem	Date of Treatment	Medication and Treatment	Prognosis

Does the patient have any medication allergies? ___ Yes ___ No. If yes, list allergies:

Medication and Allergic Reaction	
Medication	Reaction

Is patient currently receiving psychoactive medication? __ Yes __ No. If yes, list the drug, reason, potential side effects and date.

Name of Psychoactive Medication	Reason Drug is Prescribed	Start Date	Side Effects

What is this patient's ability to perform ADLs in the community and describe the level of support needed to perform activities in the community:

_____ MD	_____ MD	_____
Examining Physician (Print or Type)	Signature of Physician	Date

Physical Exam: Weight _____ Height _____ Temperature _____ Pulse _____ Blood Pressure _____

Normal	Check each item in the appropriate Column. Enter "NE" if not evaluated	Abnormal	Findings
	Head, Face, Neck, and Scalp		
	Nose, Throat, and Mouth		
	Sinuses		
	Ears, General		
	Hearing: Right ____ Left ____		
	Ophthalmoscopic		
	Pupils		
	Vision: Far _____ Near _____		
	Lungs and Chest		
	Heart		
	Vascular System		
	Abdomen and Viscera		
	Anus and Rectum		
	Endocrine System		
	G-U System		
	Upper Extremities		
	Lower Extremities		
	Feet		
	Spine, Other Musculoskeletal		
	Identifying Body Marks, Tatoos, Scars		
	Skin, Lymphatics		
	NEUROLOGICAL		
	Motor (station, gait, power, coordination)		
	Sensory (pain, temperature, touch, deep pain and vibratory sense)		
	Reflexes (superficial)		
	(deep)		
	(pathological)		
	Cranial Nerves:		
	I		
	II		
	III, IV, VI		
	V		
	VII		
	VIII		
	IX, X, XI		

Level of Care SNF _____ ICF _____ HOSPICE _____ DEFERRED _____ OTHER (Specify) _____
Physical Diagnosis: _____

_____ MD _____ MD _____
Examining Physician (Print or Type) Signature of Physician Date

State of Hawaii
Department of Health

Behavioral Health Administration
Adult Mental Health Division

Pre-Admission Screening / Resident Review
Psychiatric Evaluation Part I

_____ _____ ___/___/___ ____ ___
(Last Name) (First Name) (Middle) (Medicaid ID Number, if applicable) (Birthdate) (Age) (Sex)

_____ _____ _____ _____
(Home Address if applicable) City) (State) (Zip)

The psychiatric evaluation consists of two forms including: PSYCHIATRIC EVAUATION, PART I AND PART II: SERIOUS MENTAL ILLNESS CRITERIA. All forms must be completed. Please provide sufficient information to determine the patient's need for "active treatment/specialized services". Use the back of Part II form if additional space is needed to record your response.

1. Psychiatric History (including Drug History): Provide dates if known.

2. Current Psychiatric Condition:
   a. Is the patient a harm to self or others, i.e. suicidal or homicidal ideation, and/or exhibit externalizing and/or internalizing behaviors, i.e. physical violence, damage to property, sexually inappropriate, self abusive, or abuses unauthorized substances?

   b. Is patient delusional and/or has hallucinations?

3. Mental Status (appearance, orientation, affect and mood, thought, insight, organicity, etc.):

4. Describe Patient's Strengths and Weaknesses:

5. Estimated IQ Level:

6. Psychosocial Evaluation: Include current living arrangements, medical and support systems:

7. Recommendations / Plans of Service / Appropriate Placement:

8. Diagnosis: (A listing of applicable diagnoses is available on back of this form)

DSM – III – R	Axis I	Axis II	Axis IV	Axis V
Primary	_ _ _._ _	_ _ _. _ _	_____	___/___

_____ _____ _____
Psychiatrist/Psychologist Name and Title Signature Date

Pre-Admission Screening / Resident Review
PSYCHIATRIC EVALAUTION PART II
SERIOUS MENTAL ILLNESS (SMI) CRITERIA

_____ _____/_____/_____
(Last Name) (First Name) (Middle Initial) (Birthdate)

An individual is considered to have a serious mental illness (SMI) if the individual meets the following requirements on <u>diagnosis, level of impairment, and duration of illness</u>:

1. **DIAGNOSIS**
   The patient is 18 years or older and has a possible diagnosis within the following DSM-III-R disorders: "a schizophrenic, mood, paranoid, panic or other severe anxiety disorder, somatoform disorder personality disorder, other psychotic disorder, or another mental disorder that may lead to a chronic disability." (See Part I or Psychiatric Evaluation) ___YES ___NO

2. **LEVEL OF FUNCTIONAL IMPAIRMENT**
   On a continuing or intermittent basis for the past 3 to 6 months, the patient's mental disorder has resulted in one or more functional limitations in major life activities characterized by:

   a. Problems in interpersonal functioning: ___YES ___NO
      - Has serious difficulty interacting appropriately and communicating effectively; or
      - Has a history of altercations, evictions, being fired from a job, fear of strangers, avoidance of interpersonal relationships and social isolation.

   b. Problems in concentration, persistence and pace: ___YES ___NO
      - Has serious difficulty in sustaining attention to permit completion of tasks in work or work like settings, or in school and home settings; or
      - Manifests difficulties in concentration; or
      - Unable to complete simple tasks within an established time period, makes frequent errors or requires assistance in completing simple tasks.

   c. Problems in adaptation to change: ___YES ___NO
      - Has serious difficulty in adapting to changes associated with work, school, family or social interaction; or
      - Requires mental health or judicial interventions due to exacerbated signs and symptoms associated with the illness or withdrawal from the situation.

3. **RECENT TREATMENT OR HISTORY INDICATES THE INDIVIDUAL HAS EXPERIENCED AT LEAST ONE OF THE FOLLOWING IN THE LAST TWO YEARS.**

   a. Psychiatric treatment more intensive than outpatient care more than once; or ___YES ___NO
   b. Required supportive services to maintain functioning at home or in a residential Treatment environment; or ___YES ___NO
   c. Required intervention by housing or law enforcement officials. ___YES ___NO

IS THE INDIVIDUAL SERIOUSLY MENTALLY ILL (SMI)? ____YES___ NO

An individual is considered to be seriously mentally ill if the following criteria are met: Yes to diagnostic classification; Yes to either 2a or 2b or 2c AND Yes to either 3a, 3b, or 3c.

_____ _____ _____
Psychologist/Psychiatrist Name (Print) Psychologist/Psychiatrist Signature & Title Date signed

Preadmission Screening and Resident Review (PASRR)
For Persons With Intellectual Disability/Developmental Disabilities and Related Conditions
Hawaii State Department of Health
Developmental Disabilities Division

I. _____ _____ _____ _____ _____
Patient Last Name | First Name | MI | Sex | Medicaid #

_____
Present Address

Range (Check One):

II. DIAGNOSIS: Intellectual Disability (ID) IQ Score: _____ Mild ☐ Mod ☐ Severe ☐ Profound ☐

Other Diagnosis/Illness/Problem	Date of Onset	Current Medication/Dosage	Prognosis/Impact on Functioning

III. PHYSICAL EXAMINATION: Weight: _____ Height: _____ BP: _____

Check each item in appropriate column (normal/abnormal). Enter "NE" if not evaluated. Attach any pertinent reports.

Category	Normal	Abnormal	Description of Abnormal Conditions
Head, Face, Neck, and Scalp	☐	☐	
Nose, Throat and Mouth, Sinuses	☐	☐	
Ears – General	☐	☐	
Hearing: Right: Left:	☐	☐	
Eyes – General	☐	☐	
Vision: Right: Left:	☐	☐	
Heart and Vascular System	☐	☐	
Lungs and Chest	☐	☐	
Genitourinary System	☐	☐	
Abdomen and Viscera	☐	☐	
Anus and Rectum	☐	☐	
Endocrine System	☐	☐	
Upper Extremities	☐	☐	
Lower Extremities	☐	☐	
Spine, Other Musculoskeletal	☐	☐	
Skin, Lymphatic System	☐	☐	
Neurological System	☐	☐	
Psychiatric	☐	☐	

IV. FUNCTIONAL ASSESSMENT (to be completed by professional who knows the patient/resident best): First assess person's functional level as either independent or dependent/requiring partial assist compared to others in the age group. If the person is dependent/partial assist, then determine whether the person needs and/or may benefit from training (as opposed to short term therapy) – i.e. working in a step-wise manner to achieve/maintain goals(s) for independence using specialized techniques generally used for educating/training persons with developmental disabilities/intellectual disabilities.

	INDEPENDENT	DEPENDENT OR REQUIRING PARTIAL ASSIST MAY BENEFIT FROM TRAINING?	
		YES	NO
SELF-CARE/PERSONAL CARE:	☐	☐	☐
Able to perform necessary steps involved in bowel/bladder elimination	☐	☐	☐
Able to dress and undress self	☐	☐	☐
Able to groom and complete personal hygiene needs as bathing, brushing teeth	☐	☐	☐
Able to drink fluids, chew, and swallow foods and use utensils to feed self	☐	☐	☐
COMMUNICATION:	☐	☐	☐
Able to understand and follow simple directions	☐	☐	☐
Able to communicate one's basic needs and wants	☐	☐	☐
Can verbally communicate	☐	☐	☐
Is non-verbal – uses gestures and some single words	☐	☐	☐
COGNITIVE/SOCIAL:	☐	☐	☐
Able to retain and recall what has been learned or experienced	☐	☐	☐
Able to respond appropriately to visual or auditory stimuli	☐	☐	☐
Able to make choices with little or no direction from others	☐	☐	☐
Able to choose, initiate, and engage in leisure activities	☐	☐	☐
Able to evaluate, use logic to discriminate/generalize situations and viable solutions	☐	☐	☐
Able to discriminate gender similarities/differences and appropriate social/sexual behaviors	☐	☐	☐
Able to relate to others on a 1:1 or group basis	☐	☐	☐
MOTOR ABILITIES/MOBILITY:	☐	☐	☐
Able to perform coordinated gross motor activities	☐	☐	☐
Able to perform coordinated fine motor activities	☐	☐	☐
Able to perform eye-hand coordinated activities	☐	☐	☐
Able to independently use available transportation to get to desired destination	☐	☐	☐
Able to independently move from place to place in a wheelchair	☐	☐	☐
VOCATIONAL:	☐	☐	☐
Able to adapt to changes in job related situations (peers, supervisors, assignments)	☐	☐	☐
Able to demonstrate appropriate and acceptable job specific skills	☐	☐	☐
Able to demonstrate responsible work related behaviors as attendance, work on time	☐	☐	☐
INDEPENDENT LIVING SKILLS:	☐	☐	☐
Able to perform independent living household activities as budgeting, shopping	☐	☐	☐
Able to monitor own health status	☐	☐	☐
Able to administer own medications	☐	☐	☐
Able to schedule medical appointments and follow-up	☐	☐	☐
Able to monitor own nutritional status, including making meals	☐	☐	☐

NEEDS ADAPTIVE DEVICES TO PERFORM ANY/ALL OF THE ABOVE: SPECIFY
(e.g. prosthesis, orthosis, hearing aid, visual aid, communication device)

V. EXERNALIZING AND INTERNALIZING BEHAVIORS(S):	FREQUENCY (specify day/week/mo.)	MILD	MOD	SEVERE
Physical violence against others		☐	☐	☐
Damage to property		☐	☐	☐
Sexually inappropriate		☐	☐	☐
Self-abusive		☐	☐	☐
Abuse of unauthorized substances		☐	☐	☐
Other:		☐	☐	☐
Other:		☐	☐	☐
Other:		☐	☐	☐

VI. PSYCHOSOCIAL EVALUATION: Current living arrangements, medical and support system

Name of Examining Physician _____ Signature of Physician _____ Date _____