MDS Alert

Care Planning: Ensure Facility Protocols for Implementing PASRR Recs

Assure person-centered care and avoid citations by following through on PASRR recommendations.

Boost your chances at escaping a survey without citations by understanding how to incorporate the Preadmission Screening and Resident Review (PASRR) process into your facility's assessment process and into individuals' comprehensive care plans. The PASRR process is designed to screen residents for mental illnesses or disorders (MI or MD) or intellectual disability/developmental disability (ID/DD) and, if the resident "tests positive," provide a roadmap for how to formulate a plan for caring for each individual and to make certain the resident is going to receive the appropriate level of services in the nursing facility setting.

However, some facilities have been struggling with survey citations due to PASRR issues.

"In reviewing deficiencies cited on surveys related to PASARR and assessments, there are several systems issues that repeatedly pop up," says **Linda Elizaitis, RN, RAC-CT, BS, CIC,** president of **CMS Compliance Group** in Melville, New York.

Background: The PASRR requirement came about via the 1987 Omnibus Budget Reconciliation Act and has since been adjusted to its current form through tweaks from the Americans with Disabilities Act (ADA) and the Supreme Court case Olmstead v. L.C. Ostensibly, it's intended to make sure that care paid for by Medicaid dollars is not tied to the person's home - recipients need not be in a facility if they could receive appropriate care for their needs elsewhere in the community.

"PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care … The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care," says the **Medicaid.gov** website.

Although each state has its own Medicaid agency and much of the PASRR process is left up to individual state's determinations, the PASRR is an item on the MDS and is required to be performed by all Medicaid-certified nursing facilities, regardless of the resident's payer. There are two levels of the PASRR process: Level I, which is necessary for all residents, and Level II, which is utilized only if the resident in question tests positive to Level I.

PASRR can be extremely confusing because the interpretation and enforcement of its requirements can vary from state to state, and because the PASRR process involves multiple steps and various agencies, at both the state and federal levels.

Troubleshoot PASRR

If you've recently been cited by a state surveyor in relation to PASRR or have a survey coming up, consider these issues.

"First, many residents are given a PASARR Level I time-limited waiver for 30 days, but they end up remaining in the facility longer without follow up from the facility or notification to the state-designated authority," Elizaitis says.

Other citable issues crop up when the interdisciplinary care team (or whoever is creating care plans) doesn't care plan around the PASRR findings. "Second, facilities fail to act upon PASARR Level II recommendations by not incorporating them into the individual's person-centered care plan. Facilities can also encounter difficulties when they fail to contact the appropriate agency for a Level II Review following a significant change in status, new MI or ID/DD diagnosis or a change in Categorical Determination when a SCREEN is completed, all of which should impact the plan of care," she says.

Surveys may become problematic because of the "formula" surveyors use to designate residents included in the provider matrix. Don't allow the confusing language to set you up for a citation when it comes to PASRR.

"On survey, the provider matrix asks facilities to include any residents who have a serious mental disorder, intellectual disability or a related condition but who do not have a PASARR Level II evaluation and determination in place. This increases the likelihood of an assessment error being identified," Elizaitis says.

Focus Care on Meeting Needs

Consider how your facility can streamline the comprehensive care plan process to make sure that any particulars for care unearthed by the PASRR process are actually made part of the care plan.

"A specific PASARR comprehensive care plan is not required, but all of the Level II recommendations need to be incorporated into the comprehensive care plan. There should be clear documentation in the care plan regarding interventions related to how the facility is addressing the specialized services and rehabilitative services noted in the Level II determination that the resident requires," Elizaitis says.

"Things to think about related to care-planning as it comes to the needs with individuals with mental disorders or intellectual disabilities (MD/ID) first and foremost requires that the facility has procedures in place to ensure that recommendations made are incorporated into the plan of care," Elizaitis says.

When care planning for a PASRR-positive resident, really delve into specifics. You may need to reach out to colleagues whom you don't usually involve in the care planning process.

"The care planning process of course needs to be interdisciplinary, but it is very important to ensure that psychiatry and medical services are made aware of the plan of care and are involved in the process. When it comes to individuals who have been diagnosed with mental disorders, psychiatry really should be involved in driving the care planning process," Elizaitis says.

Consider both management of the resident's current needs and realities, as well as a focus on longer-term goals. Care planning with PASRR in mind may mean drawing more on resources available throughout the resident's community and not just within the facility itself.

"Interventions for these individuals must be person-centered and may require consults to be completed as well as specific actions from multiple departments. This includes psychiatric evaluations or psychology services, if ordered, as well as rehab services (if applicable), ensuring the social worker visits to address concerns such as behavior management, specialized services, community resources, discharge planning, and other needs, as well conducting follow-up to ensure the resident is involved in activities and groups that take into account her individual interests and needs," Elizaitis says.

Note: Though PASRR is on the MDS, it's more of an additional tool a facility can use in determining appropriate care rather than just a record of assessment. A PASRR may be required upon admission or at the point of a Significant Change in Status Assessment (SCSA). "PASRR is not a requirement of the resident assessment process, but is an OBRA provision that is required to be coordinated with the resident assessment process. This guideline is intended to help facilities coordinate PASRR with the SCSA - the guideline does not require any actions to be taken in completing the SCSA itself," says the **RAI Manual** on page 2-28.

Important: Don't forget that a SCSA may trigger another PASRR, and that figuring out and implementing appropriate care shouldn't depend on the timeliness of the SCSA. "Referral should be made as soon as the criteria indicating such are evident - the facility should not wait until the SCSA is complete," the RAI Manual says on page 2-28.