PASRR/Update Level II Evaluation ☐ MI ☐ ID ☐ DU

For BOCK use only

RedCap _____ ☐ Pre-Admission Screening ☐ Resident Review ☐ Check if DMH Re-determ

PASRR Outcome: ☐ SMI ☐ IDD/RC ☐ Unable to verify SMI ☐ Unable to verify IDD/RC ☐ Primary Dementia

Needs exceed NF Level of Services? ☐ No ☐ Yes/MI ☐ Yes/ID Additional services? ☐ No ☐ Yes

Re-evaluation required? ☐ No ☐ 180 Days ☐ Other: _____

SECTION I: Identification

1. Name (Last, First, MI) _____ 2. Date of Birth _____ 3. Gender Male ☐ Female ☐

4. DCN _____ 5. Evaluation Date _____ 6. Date of previous Level II: _____

7. Current Location: NF ☐ Hospital ☐ Home ☐ RCF/ALF ☐ ISL ☐ Other ☐ _____

8. Facility Name _____ Admit Date _____

City _____

Contact _____ Phone _____

9. Over 30 months continuous NF stay? Yes ☐ No ☐

10. Does the individual have a **LEGAL GUARDIAN?** No ☐ If Yes, complete the following:

Name _____

Address _____

City _____ State MO Zip Code _____

Relationship: [Select or type response] _____ Phone _____

SECTION II: Psychiatric Assessment/History

1. Please list all documented historical and current **psychiatric** and ID/DD **diagnoses** (include date of diagnosis if available).

2. Describe any **medical conditions** that could exacerbate, mimic, be related to mental illness symptoms, or considered a DD related condition.

SECTION II: Psychiatric Assessment/History (continued)

3. Provide an update of the individual's mental status, psychiatric symptoms, and behaviors since last evaluation including any current **mood disturbance, anxiety related symptoms or disturbance in thought** content/process/reality testing.

4. Provide an update of the individual's hospitalizations, services and psychiatric treatment since last evaluation. Include services received through the Missouri Department of Mental Health and the Missouri Division of Developmental Disabilities regional office.

5. Describe any **alcohol and/or drug abuse** since last evaluation? None ☐

6. **Current** psychiatric support/services. **Mark all that apply.**

- ☐ None
- ☐ Psychiatric follow-up/consultation
- ☐ Day program/partial hospital program
- ☐ Inpatient psychiatric treatment
- ☐ Individual therapy/counseling
- ☐ Medication administration/management/monitoring
- ☐ Sheltered workshop
- ☐ Supported community living/Independent supported living
- ☐ Group therapy/counseling
- ☐ Secured/behavioral unit
- ☐ ECT
- ☐ DMH Services (specify): ☐ CPS ☐ DD ☐ ADA
- ☐ Safety precautions (specify): _____
- ☐ Other (specify): _____

SECTION II: Psychiatric Assessment/History (continued)

7. Any recent OR current thoughts/plans/acts/ideation or intention of **suicide or self injury**? ☐ No ☐ Unknown If yes, describe:

8. Any recent OR current thoughts/plans/acts/ideation or intention of **homicide, aggressive/assaultive or violent** behavior? ☐ No ☐ Unknown If yes, describe:

SECTION III: Behavioral Assessment

1. Behaviors None ☐ If yes, please indicate which of the following behaviors are problematic for the individual **within the last 30 days** based on the individual's medical record or staff comments.

- ☐ Unsafe smoking behavior
- ☐ Refuses medications
- ☐ Refuses activities
- ☐ Refuses to eat
- ☐ Uncooperative with diet
- ☐ Uncooperative with hygiene
- ☐ Self induced vomiting
- ☐ Frequent/continuous yelling
- ☐ Intrusive/invades others space
- ☐ Impatient/demanding
- ☐ Wandering
- ☐ Alcohol/drug use
- ☐ Destroys property
- ☐ Exposes self
- ☐ Sexually aggressive
- ☐ Verbally abusive
- ☐ Verbally threatening
- ☐ Uncooperative with medical/nursing care or treatments
- ☐ Cursing/swearing
- ☐ Disturbs other residents
- ☐ Physically threatening
- ☐ Strikes others provoked
- ☐ Strikes others unprovoked
- ☐ Elope/leave facility
- ☐ Seclusiveness
- ☐ Injures self
- ☐ Suspicious of others
- ☐ Lies purposefully
- ☐ Steals deliberately
- ☐ Talks of suicide/ideation
- ☐ Passive death wish
- ☐ Suicide threats
- ☐ Suicide attempts
- ☐ Verbalizations or crying out
- ☐ Other (specify): _____

2. Describe frequency and intensity of behaviors and staff response to behaviors noted above. ☐ N/A

3. Placement in Seclusion/Restraints. In the last 30 days has the individual been placed in seclusion or restraints to control dangerous behavior? ☐ No If yes, describe:

SECTION IV: MI/IDD/RC Determination

1. **Mental Health disability.** Based on the previous Level II evaluation and current documentation the individual:

- ☐ Has a mental health disability as defined by PASRR
- ☐ Does not have, or absence of clear evidence to substantiate/validate mental health disability as defined by PASRR
- ☐ Has primary Dementia
- ☐ N/A (This is an ID Referral only)

2. **IDD/Related Condition.** Based on the previous Level II evaluation and current documentation the individual:

- ☐ Has IDD or a related condition (other than mental illness) as defined by PASRR
- ☐ Does not have, or absence of clear evidence to substantiate/validate IDD or related condition as defined by PASRR
- ☐ N/A (This is an MI Referral only)

3. If either of the above determinations differ from the previous Level II evaluation please provide detail below.

4. Does the individual need further evaluation for possible mental illness, dementia, and/or intellectual/developmental disability? ☐ No If yes, describe:

If the individual DOES NOT meet criteria for a PASRR related mental health disability and DOES NOT meet criteria for a PASRR related ID disability proceed to Section: Conclusions. If the individual DOES meet criteria for a PASRR related disability continue with evaluation.

SECTION V: Psychosocial Assessment

1. Specify reason for **NF application, admission or continued stay(check all that apply)**

- ☐ A. Assistance needed to complete ADLs (eating, dressing, grooming, bathing, incontinence care)
- ☐ B. Assistance needed for transfers, ambulation, fall prevention
- ☐ C. Rehabilitation services needed (physical, occupational, speech therapy)
- ☐ D. Medical treatment and/or monitoring for acute condition. Treatment needed due to new/recent diagnosis or condition, short term medical care needs.
- ☐ E. Medical treatment and/or monitoring for chronic conditions with treatment services needed on regular basis in NF setting.
- ☐ F. 24 hour protective oversight needed due to severity of behaviors or mental illness symptoms. Individual cannot be without supervision at any time.
- ☐ G. Physical care needs exceed what can be managed in previous/current living situation
- ☐ H. Alternative care options are unavailable due to lack of funding or availability/wait list for RCF/ALF, low income housing, no DD waiver, or no available slots or providers, etc.
- ☐ I. Housing instability/homeless
- ☐ J. Mental health care needs exceed what can be managed in previous/current living situation due to aggression, substance use or medication noncompliance leading to exacerbation of symptoms.
- ☐ K. Other: _____

SECTION V: Psychosocial Assessment (continued)

2. Describe current **family** state. What kind of support system/resource is the family? Who are the primary contacts? Where do they live?

3. Typical **Daily Activities**. Per individual and/or staff report describe how the individual spends most of her/his time (important activities, hobbies, interests).

SECTION VI: Level of Functioning

Coding: I = Independent V = Verbal assist, supervision, or set up P = Physical assist

1. Personal care and independent living skills:

____ Toileting	____ Selects appropriate clothes	____ Scheduling of medical treatments
____ Personal hygiene	____ Dressing/undressing	____ Monitoring of health status
____ Brushing teeth/oral care	____ Bathing	____ Handling money
____ Eating		

Comments: _____

2. Mobility/Gait **(mark all that apply)**

☐ Normal/Fully independent	☐ Aids (cane/walker)	☐ Unsteady	☐ Staff assist
☐ Wheelchair unassisted	☐ Wheelchair assisted	☐ Bedfast	☐ Other: _____

3. Describe the individual's **communication** and interaction with others.

SECTION VII: Medical History and Physical Assessment

1. Does the individual have any medication allergies? ☐ No

   If Yes, specify: _____

2. Has the client been compliant with medication instructions since last evaluation? ☐ No ☐ Yes ☐ Unknown

3. Current Medications. Record current meds (include drug name, dosage, frequency, and start date), excluding convenience meds or attach current MAR/Physician Orders/POS.

   ☐ Current MAR /Physician Orders/POS attached Date: _____

4. Describe individual's response to hypnotics, anti-psychotics, mood stabilizers and anti-depressants, anti-anxiety/sedative agents, and anti-Parkinson agents. ☐ N/A

5. Describe the individual's ability to self-administer physician-prescribed medications: _____

6. Provide an update of medication changes since last evaluation.

7. Has the individual received an emergency (STAT) or PRN administration of medications to control behavior in the last 30 days?

   ☐ No If Yes, describe:

SECTION VII: Medical History and Physical Assessment (continued)

8. List all current and historical medical diagnoses and status as documented in the individual's record

☐ Current Diagnosis List/History & Physical Attached Date: _____

9. Appetite: _____

10. Sleep Pattern **(mark all that apply)**

☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep
☐ Receives medication ☐ Severely disturbed pattern ☐ Hypersomnia/daytime sedation
☐ Other: _____

11. Does the individual currently receive any special **medical treatments**/supports?

☐ No If Yes, please indicate which of the following treatments the individual receives **(mark all that apply)**

☐ Blood transfusions ☐ Foot care ☐ Monitoring of Vital Signs
☐ Bowel and bladder/Incontinence care ☐ Fracture care ☐ Oral suction
☐ Catheterization care ☐ Hemodialysis ☐ Oxygen
☐ Choking/Aspiration precautions ☐ Hospice Services ☐ Prosthesis care
☐ Colostomy/Ileostomy/Ureterostomy ☐ Inhalation therapy/Respiratory care ☐ Seizure precautions
☐ CPAP/BIPAP ☐ Injections ☐ Special skin care/monitoring
☐ Diabetic monitoring ☐ Intake and output ☐ Tracheostomy care
☐ Dietary supplements ☐ IV fluids ☐ Tube feedings/TPN
☐ Decubitus care ☐ IV meds/antibiotics ☐ Weight monitoring
☐ Dialysis ☐ Medication monitoring ☐ Wound/incision care
☐ Fall precautions ☐ Therapeutic diet (specify): _____
☐ Ordered labs (specify): _____
☐ Other (specify): _____

12. Rehabilitation services. Does the individual receive any type of rehabilitative services?

☐ None ☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy ☐ Restorative nursing services

SECTION VIII: Nursing Facility/Community Interest

1. Describe **living situation** since last evaluation.

2. Describe any **d/c planning**, progress towards transition to, or trials in, community since last evaluation. For DMH re-determinations contact legal guardian, DD Service Coordinator, etc. as applicable.

Active Discharge Plan? ☐ No ☐ Yes ☐ N/A or Unknown

3. **Nursing Facility Interest.** What are your thoughts or feelings about going to or remaining in a Nursing Facility? What are your preferences regarding your current and future living situation?

4. **Community Interest.** Are you interested in the possibility of returning to live and receiving services in the community instead of a Nursing Facility? ☐ No ☐ Yes ☐ Unknown/Unable/Unwilling to answer

5. Summarize **MDS Section Q**. ☐ Not provided by facility ☐ N/A or Not Requested/Required

SECTION IX: PASRR Level II Evaluation Report

Client Name: _____

1. **Mental Health disability.** Based on the previous Level II evaluation and current documentation the individual:

- ☐ Has a mental health disability as defined by PASRR
- ☐ Does not have, or absence of clear evidence to substantiate/validate mental health disability as defined by PASRR
- ☐ Has primary Dementia
- ☐ N/A (This is an ID Referral only)

2. **IDD/Related Condition.** Based on the previous Level II evaluation and current documentation the individual:

- ☐ Has IDD or a related condition (other than mental illness) as defined by PASRR
- ☐ Does not have, or absence of clear evidence to substantiate/validate IDD or related condition as defined by PASRR
- ☐ N/A (This is an MI Referral only)

3. Provide a **summary** of the client's medical and social history

4. Individual's **limitations** (developmental needs, physical, communication, memory, needs, etc.)

5. Individual's **strengths** (positive traits and developmental strengths, abilities, accomplishments, personal traits, etc.)

6. Has a prospective Nursing Facility been identified? No ☐ N/A (Currently in NF) ☐

If Yes, please indicate facility name: _____

SECTION IX: PASRR Level II Evaluation Report (continued)

7. Nursing Facility Level of Services? (check all that apply)

- ☐ The individual's needs could be met in a nursing facility at this time.
- ☐ Community alternatives to nursing facility should also be considered, if available, with supports listed in #9.
- ☐ The individual's mental health and/or intellectual disability service needs cannot be met in a nursing facility at this time.
  - ☐ Requires 1:1 supervision to maintain safety due to behavioral/mental health symptoms
  - ☐ Recent/current aggressive/violent behavior requiring seclusion, restraints, PRN medications etc.
  - ☐ Current/active homicidal ideation
  - ☐ Current/active suicidal ideation/self harm
  - ☐ Medication refusal leading to acute exacerbation/continuation/instability of psychiatric symptoms
  - ☐ Other (specify): _____

Provide discussion/supporting documentation for the recommendations listed above.

If the individual requires services beyond the capabilities of a nursing facility contact Bock before proceeding and skip to Section: Conclusions.

8. The individual needs, or continues to need, the following specialized mental health services?

- ☐ Psychiatric diagnostic evaluation
- ☐ Individual, family, or group psychotherapy
- ☐ Psychotherapy for crisis
- ☐ Health behavior assessment and intervention
- ☐ Tobacco cessation counseling
- ☐ None

SECTION IX: PASRR Level II Evaluation Report (continued)

9. The individual needs or continues to need the following supports and services.

☐ A. Provision of specific services to address the individual's **mental health and behavioral needs**.

- ☐ Obtain Individual Support Plan (ISP), Individualized Treatment Plan (ITP), Behavioral Support Plan (BSP) from DMH Community Mental Health Center and/or Developmental Disability Regional Office.
- ☐ Monitoring of behavioral symptoms
- ☐ Trauma informed services
- ☐ Tools of choice or other Positive Behavioral Support services

☐ B. **Medication** therapy and monitoring services

- ☐ Psychiatric follow up to prescribe and manage medications
- ☐ Medication set up/administration by staff and monitoring for compliance with prescribed medication
- ☐ Monitoring of therapeutic effect in managing mental health symptoms, including therapeutic levels, and/or interaction or adverse effects
- ☐ Provide education/training in drug therapy management
- ☐ Other: _____

☐ C. Provision of a **structured environment**.

- ☐ Maintain environment with low stimulation, minimum of visual/auditory distractions, and/or sensory supports
- ☐ Provide instructions at the individual's level of understanding
- ☐ Environmental supports to prevent elopement
- ☐ Assess and plan for the level of supervision required to prevent harm to self or others
- ☐ Provide for individual personal space
- ☐ Establish consistent routines, providing a schedule of daily tasks/activities, etc.

☐ D. **Crisis Intervention** Services. Assess and plan for Crisis Intervention that provides emotional support, education, safety planning and case management to handle an immediate crisis. A crisis plan should developed to create clear steps that are to be taken to support client during a behavioral health crisis including who to contact for assistance, how to work together with client during the crisis, and how to determine when the crisis is over. The plan should also identify a physician and emergency medical services that should be contacted. Facility may also wish to utilize DMH Behavioral Health Crisis Hotline: https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/behavioral-health-crisis-hotline

☐ Suicidal precautions ☐ Assault precautions ☐ Elopement precautions

SECTION IX: PASRR Level II Evaluation Report (continued)

☐ E. Implementation of **ADL program** to increase independence and self determination.

Assess and plan a program for the development and maintenance of necessary living skills including **(mark all that apply)**:

☐ Grooming/dressing ☐ Nutrition needs ☐ Bathing

☐ Personal Hygiene ☐ Money Management ☐ Maintenance of own living environment

☐ Toileting/bowel/bladder ☐ Other: _____

By providing the following services **(mark all that apply)**

☐ Physical therapy evaluation and/or treatment

☐ Occupational therapy evaluation and/or treatment

☐ Speech-language pathology evaluation and/or treatment

☐ Restorative services (for turning/positioning, transferring, ambulation, ADLs, range of motion, bowel/bladder program

☐ Provision of, training or assistance in use of adaptive equipment or assistive devices

☐ Dietary or nutritional services

☐ Provide cueing, reminders, education and/or modeling of daily living skills

☐ F. Development of **Personal Supports**

☐ Assess and plan for meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc.

☐ Assess, plan, and develop appropriate personal support network through community and social connections.

Provide comments regarding any Support and Services previously selected.

SECTION IX: PASRR Level II Evaluation Report (continued)

☐ G. Assess and plan for **discharge**, transition to less restrictive environment by application/referral to appropriate community resources. Facility/staff to make referral and assist with application for resources and/or services. Describe and specify:

Identify what supports/services may be needed for the individual to live successfully in a **less restrictive/community setting**.

Substance use services:

☐ 1. Community based substance use treatment

☐ 2. 12 step/substance use program

☐ 3. Residential/Intensive substance use treatment/Rehabilitation services

DD Support Services

☐ 1. Referral to DMH/DD Regional Office for intake/eligibility evaluation

☐ 2. Application for DD/Waiver Services

Housing assistance:

☐ 1. Intensive Residential Treatment Services (IRTS)/Psychiatric Individualized Supported Living (PISL)

☐ 2. Cluster apartment services

☐ 3. Residential Services (RCF/ALF)

☐ 4. Permanent supported housing

☐ 5. DD Residential/Independent Supported Living (ISL)

SECTION IX: PASRR Level II Evaluation Report (continued)

Community based psychiatric treatment and supports:

- ☐ 1. Group counseling/psychotherapy/support group
- ☐ 2. Individual counseling/psychotherapy
- ☐ 3. Medication education/counseling/set-up/administration
- ☐ 4. Skills training/vocation rehabilitation/supported employment
- ☐ 5. Community Psychiatric Rehabilitation/Case Management
- ☐ 6. Psychiatric follow-up/Physician services
- ☐ 7. Intensive Community Psychiatric Rehabilitation (ICPR)
- ☐ 8. Peer Support Services
- ☐ 9. Crisis Stabilization Services/Mobile Crisis Response
- ☐ 10. Behavioral analysis/monitoring/development of behavioral support plan
- ☐ 11. Integrated Treatment for Co-Occurring Disorders (ITCD)

Home and Community Based Services:

- ☐ 1. Day programming/Adult day care
- ☐ 2. Housekeeping/homemaker/chore services
- ☐ 3. Nutritional/dietary evaluation/delivered meals or shopping assistance
- ☐ 4. Personal care/ADL assistance
- ☐ 5. Respite care
- ☐ 6. Adaptive equipment evaluation/Environmental accessibility adaptations
- ☐ 7. Financial assistance/financial management services
- ☐ 8. Family support/education
- ☐ 9. Supported decision making
- ☐ 10. Hospice services
- ☐ 11. Medical follow-up/Physician services
- ☐ 12. Home health/nursing care services/nurse visits
- ☐ 13. Physical therapy evaluation
- ☐ 14. Occupational therapy evaluation
- ☐ 15. Speech/Language therapy evaluation
- ☐ 16. Other (describe): _____

Comments regarding Supports/Services

SECTION IX: PASRR Level II Evaluation Report (continued)

10. Describe any additional information to be utilized by the nursing facility for care planning purposes.

SECTION: Conclusions

Source of information used in completing evaluation:

- ☐ Client interview
- ☐ Previous PASRR (date): _____
- ☐ Record review - previous facility (specify): _____
- ☐ Record review - Regional Office (specify): _____
- ☐ Record review - Community Mental Health Provider (specify): _____
- ☐ Staff interview (specify): _____
- ☐ Family/guardian (specify): _____
- ☐ Case Manager (specify): _____
- ☐ Other (specify): _____
- ☐ Record review - current facility
- ☐ CIMOR

Assessor Name: _____ Date: _____

Signature: *** Signature on File *** Title _____

For BOCK USE ONLY:

Reviewed/Edited by: _____ Date: _____