

The *Level I PASRR Form* is used to identify individuals who may be subject to a *Level II PASRR evaluation* (those *known or suspected* as having diagnoses of Major Mental Illness [MMI], Mental Retardation [MR], and/or Developmental Disabilities [DD]). The Level I PASRR form applies to applicants and residents of all Medicaid certified nursing facilities, regardless of the individual's method of payment. This form must be completed on all individuals prior to NF admission. This format is consistent with federal requirements for identifying individuals with known or suspected MMI, MR, and DD. Screening information can be entered two ways:

- ~ Online at www.pasrr.com
- ~ Complete the Level I PASRR form and fax to Ascend at 1.877.431.9568 or enter online when number 28 is answered *yes*.

 Note: Advantages to completing the Level I online at www.pasrr.com:

- *Increased efficiency* by providing the ability to submit all information at one time (**including** the questions historically asked by Ascend reviewers when certain presenting information is present).
- *Increased accessibility* by offering the capacity to submit information 24-hours per day, 7 days per week, 365 days per year, along with **the capacity to obtain a decision for the majority of individuals about the need for Level II evaluation (or the approval for admission when a Level II is not needed) without delays.**
- *Increased expediency* through the ability to obtain approvals for Exempted Hospital Admissions (for individuals with mental illness, mental retardation, and developmental conditions) and **proceed with many of those admissions through computer authorization. If a paper-based PASRR Level I screen is submitted, DDM authorization must be required before an Exempted Hospital admission can occur.**
- *Immediate information access and improved communication between referring agencies and admitting nursing homes* through the ability to electronically print the completed web-based form (and authorizations when the admission approval is granted) for the admitting nursing home, signifying to the admitting facility that appropriate approvals were provided. The web-based system will allow the person entering the information to print both the screening information and a description of the outcome.
- *Federal compliance and reduced exposure for nursing homes through providing nursing homes with documentation* of all information reported to Ascend so that, in the event of a state or federal audit, the basis for the Level II referral decision is clearly provided.
- *HIPAA Compliance* through the web-based system which only allows *submission* of information, with users unable to gain access to Ascend's database or any client data. Our web-based data is HIPAA compliant and integrates access control, authentication, and a 128-bit encryption key signed by Verisign to guarantee the security of network connections, the authenticity of local and remote users, and the privacy and integrity of data communications. As a contractor of the State of Colorado, Ascend maintains fully compliant HIPAA practices with all communications about personally identifiable client information
- *'User Friendly' access* with no IS/IT modifications or programming needs from providers to access information or submit screens. With web-based access, the provider simply accesses a specified internet address, enters a code (which will be provided to each facility prior to implementation), and begins entering information. The only changes necessary on the part of the provider may be to change settings on individual computers to print the completed screening information. Any special printing instructions will be provided on the website.
- *Scoring:* The outcome is scored electronically and, in many cases, will not require Ascend review as frequently as will be required when the screening form is submitted by fax.

It is recommended that the referral source gather all screening information prior to initiating the electronic screen. Information is best obtained from several sources – the individual, any family or caregivers, and the treating provider. This information is required by federal law and must accurately portray known *or suspected* conditions, behaviors, or symptoms. The following instructions should be used as a guide for completion.

Demographics: Name/Mailing Address/SS#/Date of Birth/Gender

Complete all items. Ensure that spelling and numbers are correctly entered or written. If the screening information does not include all identifying information, the screen cannot be processed.

Current Location

Identify the location category of the screened individual. *Community* includes any community placement (such as home, with family, independent living, group home, etc.).

*Provide Admission Date

If the individual is currently residing in a facility setting (medical facility, nursing facility, or psychiatric facility), provide the admission date.

Receiving Nursing Facility Name and Address

Provide the name of the nursing home that agreed to accept the client for admission. The accepting nursing home information must be provided before the screen can be submitted.

Payment Method

Provide the client’s method of payment. Note that Level I PASRR and Level II screening is required for all admissions to Medicaid certified nursing facilities, regardless of the individual’s method of payment.

Payment Method

If the individual is a Medicaid recipient or has applied for Medicaid benefits, this screening information must be submitted by the SEP and the ULTC level of care scores (page 11 of the ULTC form) must be provided.

SECTION I: MENTAL ILLNESS SCREEN

NOTE: The federal definition for mental illness is designed to include individuals with a potential for and history of episodic changes in treatment and service needs. Federal guidelines include a three component definition that includes:

Diagnosis of a major mental illness, such as Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depression, Panic Disorders, Obsessive Compulsive Disorder; -and- the individual does not have a primary diagnosis of Dementia; and

Duration: *Recent Treatment*, related to significant disruption or major treatment episodes within the past two years and due to the disorder. This might include at least one episode of hospital care for a mental disorder within the preceding two years -or- significant life disruption related to the disorder; and

Disability: referred to as *Level of Impairment* in regulatory language, is characterized by active psychiatric symptoms within the preceding six month period and related to interpersonal functioning, concentration/pace/persistence, or adaptation to change.

Each of the questions in Sections I-IV are directed at determining suspicion or presence of those components.

1. Does the individual have any of the following Major Mental Illnesses (MMI)?

These diagnoses (schizophrenia, schizoaffective disorder, major depression, psychotic/delusional disorder, bipolar disorder, or *manic depression*, and paranoid disorder) typically reflect the presence of a major mental illness and generally qualify as federally mandated conditions which automatically warrant further evaluation through PASRR. Check the box(es) to reflect applicable diagnoses. If the suspicion of one or more of these diagnoses is present, check *suspected*, and note those suspected conditions.

2. Does the individual have any of the following Mental Disorders?

These diagnoses (personality disorder, anxiety disorder, panic disorder, and situational depression) typically reflect mental health conditions that *may* require further evaluation through PASRR depending upon their *extent* and *severity*. Check the box(es) to reflect applicable diagnoses. If the suspicion of one or more of these diagnoses is present, check *suspected*, and note those suspected conditions.

NOTE: *Situational depression* (generally a recent diagnosis and short term condition that occurs as a result of the individual's life situation) should be noted in this section. A situational depression *may* require PASRR evaluation if the depression is *more severe* than or *lasts longer* than a typically reaction to life stressors. The Geriatric Depression Scale (Short Version) – *GDS-SV* – is a brief questionnaire that should be administered by the individuals submitting this screen to determine whether the individual's symptoms demonstrate concerns related to severity. The GDS has been tested and used extensively with the older population. It is a brief questionnaire in which participants are asked to respond to questions by answering yes or no in reference to how they felt on the day of administration. The GDS is a screening tool and not a diagnosis. Where a score of more than five is indicated, further evaluation through PASRR may be required. Feher et al. have concluded that the GDS is a generally valid measure of the mild-to moderate depressive symptoms in Alzheimer patients with mild-to moderate dementia. The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings. The GDS was found to have 92% sensitivity and 89% specificity when evaluated against diagnostic criteria. The validity and reliability of the tool have been supported through both clinical practice and research. The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. **A copy of the GDS is provided on the following page and additional copies may be accessed at www.pasrr.com.** Scoring Interpretation: Normal (0-4); Mild depression (5-9); Moderate to severe depression (10-15). Therefore, a score of 5 or greater is suggestive of depression. A score of 10 or more is almost always depression.

3. Does the individual have a Diagnosis of a Mental Disorder that is Not Listed in #1 or #2? (do not list dementia here)

List any additional diagnoses not provided in Sections 1 or 2. Note that situational depression must be listed in number 2, and dementia must be listed in number 12. Do not list dementia or situational depression in this section.

SECTION II: SYMPTOMS

4. Interpersonal – Currently or within the past 6 months, has the individual exhibited interpersonal symptoms or behaviors (not due to a general medical condition)?

These reflect serious interpersonal problems which generally occur when major mental illness is present. Each of the three are to be rated according to their presence/absence within the past six (6) months. **Regardless of whether a known mental illness is present, identify interpersonal symptoms which apply to the individual.**

5. Concentration/Task related symptoms- Currently or within the past 6 months, has the individual exhibited interpersonal symptoms or behaviors (not due to a general medical condition)?

These reflect concentration and performance problems which generally occur when major mental illness is present. Each of the three are to be rated according to their presence/absence within the past six (6) months. **Regardless of whether a known mental illness is present, identify task or concentration related symptoms which apply to the individual.**

6-8. Adaptation to Change – Currently or within the past 6 months, has the individual exhibited any of the following symptoms in #6, 7, or 8 related to adapting to change?

These reflect serious adaptation problems which generally occur when major mental illness is present. Each of the three are to be rated according to their presence/absence within the past six (6) months. **Regardless of whether a known mental illness is present, identify adaptation symptoms which apply to the individual.**

NOTE: If any responses in #7 are checked, the Geriatric Depression Scale (Short Version) – *GDS-SV* – questionnaire should be administered by the screener to determine whether the individual's symptoms demonstrate concerns related to severity. See instructions and discussion about the GDS-SV under question #2.

GERIATRIC DEPRESSION SCALE (GDS-SV)

Issues:

The GDS is a screening tool and not a diagnosis. Where a score of more than five is indicated, a more thorough clinical investigation should be undertaken. Feher et al.³⁷ have concluded that the GDS is a generally valid measure of the mild-to moderate depressive symptoms in Alzheimer patients with mild-to moderate dementia. *The client should be interviewed to collect the following information.*

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities or interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bored?	Yes	No
5. Are you in good spirits most of the time?	Yes	No
6. Are you afraid that something bad is going to happen to you?	Yes	No
7. Do you feel happy most of the time?	Yes	No
8. Do you feel helpless?	Yes	No
9. Do you prefer to stay at home, rather than go out and do things?	Yes	No
10. Do you feel that you have more problems with memory than most?	Yes	No
11. Do you think it is wonderful to be alive now?	Yes	No
12. Do you feel pretty worthless the way you are now?	Yes	No
13. Do you feel full of energy?	Yes	No
14. Do you feel that your situation is hopeless?	Yes	No
15. Do you think that most people are better off than you are?	Yes	No

When a score of more than five is indicated, a more thorough clinical investigation should be undertaken.
Score: _____/15

One point for No to question 1, 5, 7, 11, 13

One point for Yes to other questions

Normal ± 2

Mildly Depressed 7 ± 3

Very Depressed 12 ± 2

Jerome A Yesavage Geriatric Depression Scale Psychopharmacology Bulletin (1988) 24:4;709-711

SECTION III: HISTORY OF PSYCHIATRIC TREATMENT

9. Currently or within the past 2 years, has the individual received any of the following mental health services?

Treatment information is sought over the past two years, because of the cyclical nature of mental illness. As such, it is very important that the screener obtain information from the individual, caregivers, or others who know the client well. These services (inpatient psychiatric hospitalization, partial hospitalization, and residential treatment) are generally received by persons with major mental illness conditions. If the exact dates are unknown, obtain approximate dates from the client or caregiver. **Regardless of whether a known mental illness is present, identify adaptation applicable treatments received by the individual.**

10. Currently or within the past 2 years, has the individual experienced significant life disruption because of mental health symptoms?

Treatment information is sought over the past two years, because of the cyclical nature of mental illness. As such, it is very important that the screener obtain information from the individual, caregivers, or others who know the client well. These types of disruption (legal intervention, housing changes, or suicide attempts) often occur for persons with major mental illness conditions. If the exact dates are unknown, obtain approximate dates from the client or caregiver. Note that, to be applicable, these occurrences should be a result of the mental health symptoms (for example, if a housing change occurred due to a medical condition, this item would not be applicable). **Regardless of whether a known mental illness is present, identify disruptions reported for the individual.**

11. Has the individual has a recent psychiatric/behavioral evaluation?

If a psychiatrist, psychologist, or behavioral specialist has been consulted within the past 60 days, respond *yes*. Provide the approximate date of the consultation.

SECTION IV: DEMENTIA

12. Does the individual have a diagnosis of dementia or Alzheimer 's disease?

If the individual has received a medical diagnosis of dementia or Alzheimer's Diseases, respond *yes*. If the answer is no, proceed to question 15.

13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia?

If specific tests have been administered to verify the presence and/or progression of dementia, list those in this section.

A note about dementia: Under federal law, a person with dementia, who has no other mental health conditions, is excluded from further evaluation through PASRR. On the other hand, a person who has both dementia **and** a major mental illness is not necessarily excluded from further review – The exclusion **can only occur if the dementia diagnosis is primary** over (and more progressed than) the other mental health diagnosis. When co-occurring diagnoses are present, Federal guidelines are very strict that an exemption cannot occur unless sufficient evidence is present to confirm the progression of the dementia. The kinds of information helpful to establishing primary Dementia (when it co-occurs) include: a neurological assessment, mental status examinations, CT scans, and any other tests that establish that executive functioning symptoms (e.g., disordered memory, orientation, abstract thinking, etc.) are associated with progressed dementia.

14. If yes to #12, list currently prescribed antidepressant or antipsychotic medications listed on the Beer's list. *Note: refer to www.PASRR.com for Beer's list or enter the screen directly at that site for automatic scoring of medication criteria.

If any of the following medications are prescribed for the client, list the medication, cumulative milligrams per day, and respond *yes* or *no* to reflect whether the dosages exceed those provided below.



Daily anti-psychotic oral dosages			Daily anti-depressant oral dosages		
Generic	Brand	* Dosage mg/day	Generic	Brand	* Dosage mg/day
Chlorpromazine	Thorazine	75	Adapin	Doxepin	100
Promazine	Sparine	150	Anafranil	Clomipramine	100
Triflupromazine	Vesparin	20	Aventyl	Nortriptyline	50
Thioridazine	Mellaril	75	Celexa	Citalopram	40
Mesoridazine	Serentil	25	Desyrel	Trazadone	150
Acetophenazine	Tindal	20	Effexor	Venlafaxine	150
Perphenazine	Trilafon	8	Effexor-XR	Venlafaxine	150
Fluphenazine	Prolixin, Permitil	4	Elavil	Amitriptyline	100
Trifluoperazine	Stelazine	8	Ludomil	Maprotiline	100
Chlorprothixene	Taracian	75	Luvox	Fluvoxamine	150
Thiothixene	Navane	7	Norpramin	Desipramine	100
Haloperidol	Haldol	4	Pamelor	Nortriptyline	50
Molindone	Moban	10	Paxil	Paroxetine	40
Loxipine	Loxitane	10	Prozac	Fluoxetine	40
Clozapine	Clozaril	50	Remeron	Mirtazapine	30
Prochlorperazine	Compazine	10	Sinequen	Doxepin	100
Resperidone	Respiridal	2	Surmontil	Trimipramine	100
Olanzapine	Zyprexa	10	Tofranil	Imipramine	100
Quetiapine	Seroquel	200	Vivactil	Protriptyline	20
			Wellbutrin	Bupropion	300
			Wellbutrin SR	Bupropion	300
			Zoloft	Sertaline	100

Daily Anti-Anxiety Oral Dosages		
Anafranil	Clomipramine	150
Celexa	Citalopram	60
Effexor	Venlafaxine	200
Luvox	Fluvoxamine	200
Paxil	Paroxetine	60
Prozac	Fluoxetine	60
Remeron	Mirtazapine	45
Zoloft	Sertaline	100
Valium	Diazepam	15
Xanax	Alprazolam	2
Librium	Chlordiazepoxide	20
Klonopin	Clonazepam	10
Tranxene	Chlorazepate	20
Ativan	Lorazepam	4
Serax	Oxazepam	60
Restoril	Temazepam	30
Buspar	Buspirone	40

Anti-depressants that can be used for insomnia	
Trazadone	50 mg/day or less
Amitriptyline	100 mg/day or less
Nortriptyline	50 mg/day or less


SECTION V: PSYCHOTROPIC MEDICATIONS

15. Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months other than those listed in question 14?

List any additional psychoactive medications (antidepressants, anti-psychotics, mood stabilizers, anti-anxiety medications and/or tranquilizers) not provided in question 14 which are prescribed currently or have been prescribed over the past 6 months. If any of the medications are prescribed for the client, list the medication, cumulative milligrams per day, diagnosis, and start and end dates (as applicable). While start and end dates may be approximate, the remaining items must be provided.

NOTE: This section is assessing for TWO conditions: MR and DD. Because some individuals may have DD without MR, it is very important that all questions in this section be completed.

SECTION VI: MENTAL RETARDATION/Developmental Disability

-  NOTE: Criteria for identifying Developmental Disability

Colorado statute defines developmental disability as;

“disability that is manifested before the person reaches twenty-two years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation” (CRS 27-10.5-102).

16. Does the individual have a diagnosis of mental retardation (MR) or developmental disability (DD)?

Answer *yes* or *no* to reflect whether the individual is currently diagnosed as having either of the conditions described in the box above.

17. Does the individual have any history of MR or DD?

Answer *yes* or *no* to reflect whether the individual has ever been diagnosed with either of the conditions described in the box above.

18. Is there presenting evidence of a cognitive or behavioral impairment prior to age 22 or suspicion of MR that occurred prior to age 18?

Answer *yes* or *no* to reflect whether the individual is suspected of meeting criteria in the box above.

19. Has the individual ever received services from an agency that serves people affected by MR/DD?

Answer *yes* or *no* to reflect whether the individual has received services from an agency that typically specializes in provider services for individuals with MR or DD.

Indicative findings on mental status examination

Exam item	Dementia	Depression	Delirium
<i>General appearance</i>	Normal-to-neglected according to amount of care provided and degree of impairment		
<i>Behavior</i>	Variable	Recent self-neglect, psychomotor retardation or agitation	Restlessness, picking at clothes or bedclothes
<i>Affect</i>	Flat, apathetic, occasionally irritable	Depressed, tearful, apathetic, irritable	Fluctuates, labile. May be tearful, giggly, anxious
<i>Thought stream</i>	May be normal, depends on degree of impairment	Normal to slow	Not fluent. Fluctuating
<i>Thought form</i>	May be normal, depends on degree of impairment	Normal. Perhaps some "blocking"	Thought disorder
<i>Thought content</i>	Poverty of thought content, may be perseverative	Themes of hopelessness, helplessness, guilt, poverty, emptiness, unworthiness or paranoia. There may be suicidal ideas or intent. Possible mood-congruent delusions or somatic complaints such as constipation or contamination. Occasionally negativistic and nihilistic thoughts are of delusional intensity	There may be a variety of florid delusional beliefs of paranoid, grandiose or depressive nature.
<i>Perception</i>	Occasional hallucinatory experiences (usually auditory). May have periods of misidentification	Occasional hallucinatory experiences that are congruent with the depressive thought processes. Usually auditory hallucinations	Frequent florid and bizarre hallucinations. May be visual and in all other senses
<i>Cognition</i>			
<i>Attention and concentration</i>	Usually intact	May be poor but can be engaged	Very poor
<i>Orientation</i>	Poor	Usually unaffected but may be uninterested	Absent
<i>Short term memory</i>	Poor	Usually intact but may not want to be bothered	Absent or fluctuates

Assessing the elderly

Aggression in dementia

- Usually inexplicable by patient
- Unpredictable
- Occurs impulsively, particularly when being attended to (e.g., hygiene)
- Easily distracted from target of aggression
- Cannot remember being aggressive or why

Aggression in delirium

- May be in response to delusions or hallucinations
- Appears to be random
- Unpredictable
- Fluctuating aggressive episodes

Aggression in depression

- Occurs in setting of irritability (e.g., of wanting to be left alone)
- May be angry with him/herself

Aggression in paranoia

- Occurs in response to delusional beliefs
- Patient may be aggressive as a defense against profound fear
- Remembers aggressive outbursts and may have associated guilt
- Has clear reasons for aggression, which are associated with paranoid delusions and self-defense

Tearfulness after a stroke*

- Usually inexplicable by patient
- Not associated with sadness
- "Emotional incontinence"
- Typically associated with "pseudobulbar palsy"
- May revert to uncontrollable laughter

Tearfulness in delirium

- Emotionally labile
- Tears not sustained
- Can be distracted from sadness

Tearfulness in depression

- Occurs in setting of sustained lowered mood
- Associated with reported sadness and misery
- Other features of depression are present

Tearfulness in adjustment reaction

- Associated with recent upsetting experience
- "Understandable sadness" or anger of recent onset

Warning signs of psychiatric disturbance in the elderly

- Self-neglect
- Sudden onset or escalation in confusion
- Any self-harming behavior
- Persistent somatic complaints without organic basis
- Persistent requests for hypnotic medication
- Exhaustion of caregivers

- Repeated complaints by neighbors or the police



Notes: