

### DEVELOPMENTAL DISABILITIES ADMINISTRATION Olympia, Washington

# TITLE:RESPONDING TO PREADMISSION SCREENINGPOLICY 16.01AND RESIDENT REVIEW (PASRR) PROGRAM REFERRALS

Authority: 42 C.F.R §483.100 – §483.138 <u>Chapter 388-834 WAC</u> *Preadmission Screening and Resident Review* (PASRR)

Reference: DDA PASRR Manual

#### **PURPOSE**

The purpose of the Developmental Disabilities Administration (DDA) Preadmission Screening and Resident Review (PASRR) Program is to identify individuals with intellectual disabilities or related conditions (ID/RC) who have been referred for nursing facility (NF) care, to determine whether a NF is the most appropriate setting to meet the person's needs and to assure that the person receives any specialized services needed for ID/RC while receiving NF care. DDA PASRR policy establishes guidelines and outlines process instructions for DDA staff who work with individuals referred to NFs.

### **SCOPE**

This policy applies to DDA Field Services and State Operated Nursing Facility (SONF) staff.

#### DEFINITIONS

**Client,** for PASRR purposes, means a person who has been confirmed to have ID/RC by a DDA PASRR Assessor through the PASRR process, regardless of whether the person meets eligibility criteria to receive services from DDA.

**DDA PASRR Management System (DPMS)** is the tool used by DDA PASRR staff for completing PASRR assessments and storing PASRR data.

**PASRR Level I** means the screening completed by a referring party when an individual is being referred to a Medicaid-certified nursing facility.

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**PASRR Level II** means the evaluation completed by a DDA PASRR Assessor with a potential, or current, nursing facility resident referred by the PASRR Level I.

**Person with an intellectual disability or related condition (ID/RC)** means an individual who has an ID/RC as defined in <u>Code of Federal Regulations (CFR) §483.102</u>.

# **POLICY**

DDA staff must:

- A. Communicate to the regional PASRR team per the PASRR Regional Communication Plan when becoming aware of relevant client information;
- B. Complete the PASRR process for all individuals identified by a PASRR Level I as possibly having ID/RC, except in cases of exempted hospital discharge (certified by the treating medical professional) or categorical determination;

# **PROCEDURES**

- A. <u>Communicate to the regional PASRR team</u> **immediately** (as soon as reasonably practicable, but in no event later than one business day) according to the Regional PASRR Communication Plan when you become aware of any of the following occurrences:
  - 1. A client is hospitalized; or
  - 2. A client is referred to, or is seeking placement in, a nursing facility; or
  - 3. A client receiving nursing facility care experiences a significant change in condition; or
  - 4. A client receiving nursing facility care requests information about services or about transitioning to a community setting; or
  - 5. A request for completion of a PASRR or a <u>DSHS 14-300</u>, *Level 1 Pre-Admission Screening and Resident Review (PASRR)* form is received; or
  - 6. A hospital or nursing facility calls with questions about the PASRR program or any individual who may be eligible for PASRR. (Individuals with an intellectual disability or a related condition, as defined in Code of Federal Regulations, who are referred for NF care are eligible for PASRR. This includes some individuals who do not meet DDA eligibility.)

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- 7. If in doubt, notify the PASRR team.
- B. <u>DDA PASRR staff will complete the PASRR process</u> for all individuals identified as possibly having ID/RC by a PASRR Level I.
  - 1. The assigned PASRR team member will review the Level I for accuracy and contact the referring party if clarification or correction is needed. If the Level I has errors, the PASRR Assessor will obtain or complete a new Level I.
  - 2. If the Level I identifies an exempted hospital discharge, the PASRR Assessor will set a reminder to contact the NF by the 25<sup>th</sup> day to confirm the discharge plan. If the NF stay exceeds thirty (30) days, the PASRR Assessor will complete the Level II prior to the 40<sup>th</sup> day of the admission.
  - 3. If the Level I identifies a categorical determination for a respite of thirty (30) days or less, the PASRR assessor will set a reminder to contact the NF by the 25<sup>th</sup> day to confirm the discharge plan. The PASRR Assessor must complete the Level II before an extension beyond thirty (30) days can be approved.
  - 4. PASRR Level II determinations must be made prior to NF admission, except when the Level I identifies a significant change of condition. On occasion, the PASRR Level II determinations of whether a person has ID/RC, whether the person needs NF care, and whether the person needs specialized services for ID/RC while receiving NF care must be made before the PASRR Assessor has completed the full Level II report. In such cases, the Assessor will complete the PAN for the Notice of PASRR Determinations and distribute to the individual, legal representative, discharging hospital, and admitting NF (if applicable) prior to NF admission and will distribute the full Level II report within thirty (30) calendar days. Whenever possible, the full Level II is to be completed prior to any NF admission, and the Notice of PASRR Determinations with PAN is not used.
  - 5. If the Level I identifies a significant change of condition, the Level II must be completed within seven (7) business days.
- C. <u>Follow-up on PASRR recommendations</u> is a shared responsibility.
  - 1. <u>Regional PASRR staff</u> must:
    - a. Supply a copy of the PASRR Level I and Level II to the NF prior to NF admission. (If the Notice of PASRR Determinations was used, forward this to the NF prior to admission, with the full PASRR Level II report to follow within thirty (30) calendar days.)

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- b. If professional assessments were recommended in Section C, Item 16, of the PASRR Level II, follow up with the NF within 25 days if the evaluation report and NF care plan have not been received.
- c. Upon receipt of evaluation report and NF care plan, confirm that a plan is in place to meet the assessed need.
- d. In coordination with NF resident, legal representative, NF staff and service provider, arrange any recommended specialized services.
- e. Provide clear communication to the service provider regarding service goals and reporting expectations.
- 2. <u>Nursing facility staff</u> must:
  - a. Arrange any professional evaluations (physical therapist, occupational therapist, speech/language pathologist, etc.) recommended in Section C, Item 16, of the PASRR Level II;
  - b. Arrange those services recommended by the professional evaluation report that are part of nursing facility care as described in <u>WAC 388-97 Nursing Homes</u>;
  - c. Forward the evaluation report and a copy of the individual's care plan to PASRR staff within thirty (30) days;
  - d. Provide any information needed by providers of specialized services to safely serve a NF resident in community settings. This information could include considerations such as special diet, potential medication side effects, seizure protocol, behavioral considerations, scheduled appointments or treatments, etc.;
  - e. Advise regional PASRR team of any concerns regarding the PASRR plan or service provision; and
  - f. Notify regional PASRR team via a new Level I if a resident experiences a significant change of condition.

### **SUPERSESSION**

None

TITLE:

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Approved:

/s/ Donald Clintsman Deputy Assistant Secretary Developmental Disabilities Administration Date: March 1, 2016