PASRR LEVEL II Independent Behavioral Health Comprehensive Evaluation - Instructions

General Instructions:

- MCOs have 4 working days from receipt of the referral from OBH to complete the Level II evaluation. This shall be done at least 95% of the total referrals within that month.
- Completed Level II evaluations should be uploaded to the FTP site located at https://mvaftp.dhh.la.gov/?Command=Login
    - If system is non-functional, evaluations should be sent via secure email to OBH.PASRR@la.gov
- Please answer all questions and include explanation if information is not available.
- Attach documents utilized in the evaluation; provide an explanation for what is being done to obtain documentation if not available.
    - It is the responsibility of the MCO to obtain the required documents for both a face to face evaluation and a desk review. The MCO should obtain this information from the referral source. Referral sources are typically hospitals and nursing facilities where this information is readily available.
    - If unavailable through the referral source, the MCO can work within their provider network to obtain information
    - MCO call also verify the individual has not experienced any behavioral health claims for the 2 years prior to referral for NF placement to verify the individual does not meet criteria for SMI.
- All evaluations must be conducted face to face through interviews with the individual, staff, and their family whenever available as well as a review of supporting documentation. Exceptions to the requirement for face-to-face evaluations can only be made by OBH.
    - If unavailable through the referral source, the MCO can work within their provider network to obtain information
    - MCO call also verify the individual has not experienced any behavioral health claims for the 2 years prior to referral for NF placement to verify the individual does not meet criteria for SMI.
- The MCO shall gather additional information should OBH determine additional information is necessary for a complete evaluation.
- **All evaluations should begin with the presumption that the individual can reside in the community; placement recommendations should be made considering the least restrictive setting for the individual**
- The MCO should email OBH at OBH.PASRR@la.gov, cc'ing Jacqueline.Whitmore@la.gov and Ann.Darling@la.gov when the evaluation is uploaded. OBH, as the PASRR Level II Authority will make final placement decisions. **OBH will contact the MCO/Level II Evaluator if they have any questions or concerns about the recommendations for placement, services, or thoroughness/continuity of information included within the evaluation.**

Demographic Information

Assessment Date	Date assessment was conducted
Medicaid Number	13 digit number assigned by Medicaid
Recipient Name	Recipient's given First, Middle, and Last name; nicknames should not be provided in lieu of formal name
MCO	Name of Healthy Louisiana Plan the person is affiliated with
Age	The age in years of the client upon interview
DOB	Enter in mm/dd/yyyy format (e.g. 05/15/1973)
Ethnicity	Data definitions for ethnicity: • Non-Hispanic or non-Latino • Hispanic or Latino
Gender	Specify Male or Female
Gender Expression	Specify Male, Female, or Other
Marital Status	Data definitions for marital status: • Unknown • Never married • Married • Remarried • Separated

PASRR LEVEL II Independent Behavioral Health Comprehensive Evaluation - Instructions

	• Divorced • Widowed
SSN	Enter full nine (9) digit number, including hyphens (e.g. 000-00-0000)
Legal Status	If applicable, check whether the individual is a Judicial Civil, Judicial Civil 648 B, or Not Guilty by Reason of Insanity (NGBRI) If applicable, check whether the individual is a Judicial Civil, Judicial Civil 648 B, or Not Guilty by Reason of Insanity (NGBRI), Parole, Probation, Charges Pending, Assisted Outpatient Treatment (AOT), Judicial Civil, Court Ordered Outpatient Treatment, Legal Detainer and Other (list with description). Provide a copy of the court order if available
Power of Attorney (POA)	Note if yes or no; if yes, check if Power of Attorney is for Medical needs, Financial needs, or both provide a copy of the documents
Phone Number for POA	If yes to POA, include phone number
Curator	Note if yes or no; if yes, provide name and provide phone number on line below
Phone Number	If yes to curator, include phone number
Past Judicial Status	Include Past Judicial Status such as prior arrest, history of sexual offense, History of elderly abuse, Prior incarceration including description of charges and when those charges were rendered, and History of aggressive behavior including a description of that behavior and when the behavior occurred.
LOCUS	Enter date and score of the LOCUS • If a Face to Face evaluation is conducted, a LOCUS must be completed at that time. • If a desk review is conducted at the request of OBH, then the most recent LOCUS on file is used unless otherwise indicated by OBH.
Primary Diagnosis	Enter the primary diagnosis (from Psychiatric evaluation)
Facility / Agency / Individual Requesting Placement	This information is usually found on the fax cover sheet of the Level I PASRR or records from the provider. • Include name of person/agency to contact regarding the request for NF placement • Contact information including a viable phone number where the individual identified above can be contacted for additional information, also including a viable fax number where the final determination can be sent.
Current Location of the Individual	Location of individual at time of the evaluation, including name of facility or family member they reside with (if applicable), physical address and phone number.
Type of Referral	**OBH will provide the type of referral on the email note when requesting an evaluation.* • Pre-admission is checked if the referral is prior to nursing facility placement. • Resident review is checked for individuals already in nursing facilities who have a change in condition. • Extension request is checked when a nursing facility is requesting to extend a temporary nursing facility authorization.

Documents Reviewed/Individual Interviews

Following Items available/reviewed	Following items should be requested and reviewed regardless of the type of review conducted. This information should be the most recent information within the past year, or the last time an evaluation was conducted, whichever is sooner, and shall include the following components: • **Medical History and Physical*-** that includes complete medical history, review of all body systems, specific evaluations of the person's neurological system in the areas of motor functioning, sensory functioning, gait, deep tendon reflexes, cranial nerves, and abnormal reflexes, and in the case of abnormal findings which are the basis of NF placement, additional evaluations conducted by appropriate specialists. • **Comprehensive Medications***- including current or immediate past use of medications that could mask symptoms or mimic mental illness, side effects, or allergies • **Psychosocial Evaluation*-** including current living arrangements and medical and support systems. *(the Level II evaluation may be utilized in place of a psychosocial evaluation)*

PASRR LEVEL II Independent Behavioral Health Comprehensive Evaluation - Instructions

	• **<u>Psychiatric Evaluation</u>*-** including a complete psychiatric history, evaluation of intellectual functioning, memory functioning, and orientation, description of current attitudes and overt behaviors, affect, suicidal or homicidal ideation, paranoia, and degree of reality testing (presence of content of delusions) and hallucinations • **<u>Functional Assessment (LOCET or MDS)</u>*** o Prior to admission to a NF, the Level of Care Eligibility Tool (LOCET) will be provided by OBH-For reviews after NF admission, the MCO shall obtain the Long Term Care Minimum Data Set (MDS) from the NF. When issuing a request for evaluation, OBH will provide to the MCO the information from OAAS that speaks to whether or not the person meets nursing facility level of care. • Documentation of Primary Dementia (if available; should include CAT Scan, MRI, Neurological testing, etc.) • Any records which speak to NF placement **** Denotes required information for review. Primary source documentation/information should be attached with the submission of the Level II evaluation. This includes current evaluations listed above by physicians, medication records, and other sources utilized in the evaluation. For Psychiatric Evaluation can also include a psychiatric consultation or verification of no behavioral health claims for 2 year period prior to referral for NF Placement.***
The following individuals were interviewed	Check all individuals interviewed including the individual, family members or significant others (specifying names), legal representative/guardian/conservator (specifying names), nursing facility/hospital staff (including name and discipline), other agencies for interdisciplinary coordination (specifying organization and contact name), and other (specify contact name of person and organization they represent) Indicated if the person was able to participate in the interview; if no, providing an explanation of why they were unable to participate.

Behavioral Health History

I	Chief Complaint	Use recipient's own words to describe what the person identifies as their needs.
II	Family or Significant Other's Description of the present Complaint	The description of the problem from the family or significant other's perspective. Include the name of the individual providing the information as well as their relationship to the applicant.
III	Presenting Problem/History of Present Illness	This section is intended for a narrative account of why the client is seeking services. It should include information on the precipitating factors leading up to the request for NF placement as well as a summary of issues (medical/behavioral health) including any information available on the onset and progression of the illness(es) and the treating providers including both Medicaid and Medicare funded services.
IV	Current Behavioral Health Provider/Prescriber	This section is intended to provide specific information regarding the individual's current behavioral health treatment. Check N/A if the individual does not currently have a behavioral health provider/prescriber. If the individual does have a behavioral health provider/prescriber, complete providing information as available from records, individual, family, and/or from MCO data regarding: • the name of the agency providing services • phone number of the provider • date services began • last appointment • name of mental health professional rendering services • summary of services rendered by provider • specify if it is medication management (yes/no)

PASRR LEVEL II Independent Behavioral Health Comprehensive Evaluation - Instructions

		• check whether the service being funded by Medicare (yes/no) describe behavioral health services received beyond medication management and the individual's level of participation/engagement in those services.
V	Past Psychiatric History	This section is intended to give information about prior psychiatric treatment, reasons and outcome of treatment. Information should be obtained from individual, family, record review, and/or MCO data.
	Prior outpatient treatment last 2 years	Indicate if received outpatient treatment within the past two (2) years (yes/no); if yes, specify the services provided with additional detail regarding the location and dates services were rendered. If other, please describe the service provided.
	Psychiatric Hospitalizations last 2 years	Indicate if received psychiatric hospitalizations in the last two (2) years (yes/no); if yes, further specifying if the hospitalization was due to a Neurocognitive diagnosis (yes/no). List locations and dates of psychiatric hospitalizations.
	Additional Comments Regarding Behavioral Health Treatment	This section is intended to provide an opportunity for the evaluator to expound on information provided above. Provide additional comments regarding past psychiatric history, including reason for treatment, types of treatment provided, type of treatment provided during in-patient treatment, complications encountered during treatment and if admitted due to legal reasons.
	Significant Decline in past three (3) to six (6) months	• This section is intended to provide an opportunity for the evaluator to indicate if the individual has had a significant decline in their psychiatric functioning that has resulted in legal/judicial involvement, loss of housing, crisis intervention, bizarre behavior, or other (including a description). Check all that apply, providing a detailed description of the behaviors noted.
VI	Substance Use/Dependence	This section is intended to capture substance use issues. Check any/all that apply for a 12 month look back period. If other, please describe.
	Substance Use Treatment History	Check the type of treatment received, including the date/location in the description. • Outpatient • Residential/Inpatient • Detox • Groups • Other(describe) List substances used within the last 30 days, including age at first use, years in lifetime, days in past 30 days, days since last use, the amount used, and route of administration.

Physical/Medical History

VII	Medical Eligibility	Indicate whether or not person meets eligibility for NF placement as determined by the Level I Authority (yes/no) This information will be provided with the referral from OBH and will either be comprised of LOCET/Level I forms, MDS, or statement from OAAS indicating whether or not Level of Care is met. If a resident review, should operate with the assumption the individual meets NF LOC.

PASRR LEVEL II Independent Behavioral Health Comprehensive Evaluation - Instructions

	Current Medical Condition	Check all current medical conditions that apply, including date of onset and stage of illness as indicated; include source of medical condition and description. Review Medical Documents such as history/physical, medical progress notes and the MDS, providing copies of documents reviewed.
	List Source	Identify where information was obtained to identify medical problems
VIII	Allergies	List all known allergies. If none indicate no known allergies.
IX	Current Medications	List current and past medications, dosages, frequency, route and any side effects or adverse reactions in detail, and response to treatment. Reasons for prescribing medications and discontinuing medications and attach documentation utilized. Submit copy of the medication list.
X	Primary Care Physician	Name of primary care physician and contact information. Specialty of the physician
XI	Medication Compliance	Indicate whether or not the individual has a history of non-compliance with medication (yes/no); if yes, describe. Indicate whether or not the individual has the ability to administer their own medication without supervision (yes/no); please describe, further explaining how medication compliance can be accomplished.
XII	Additional Medical History	Additional space to provide medical history and diagnosis (head traumas, major injuries, hospitalizations, neurological assessments, psychological (testing) etc. Identify source of information and provide a copy of the documents reviewed
	Additional Medical History	Check if the at individual is receiving one of the following therapies: Speech Therapy, Occupational Therapy, Physical Therapy, Wound Care providing an explanation if checked.

Social History

XIII	Family History	Check all that apply within current adverse circumstances, current family stress, and current family supports. Include additional comments as appropriate.
	Additional Comments	Elaborate on items identified above or describe additional issues that may have or had a significant impact on the individual's life.
XIV	Trauma History	Check all that apply and give a brief explanation. Identify the source of the information and provide documentation if available
XV (a)	Living Situation Primary Residence	Current living situation including primary residence, how long at residence, list individuals living in home, source of meals/food, means of transportation and any additional comments regarding housing situation
	Homelessness	Check if the individual has ever been homeless (yes/no) If yes, give dates and describe living situation. Provide additional comments, describing how it affected their mental and physical health.
(b)	Preferences	Identify and describe what the individual and/or their family think will enhance the individuals living situation.
(c)	Abilities/Interests/Strengths	Describe abilities /interests/strengths that might assist his/her ability to maintain housing or to obtain housing. List assets, service options and resources the person has including available housing options.
(d)	Nursing Home Placement	Check whether or not the individual wants NF placement; if yes, how long? Provide a description for why they want NF placement.

(e)		Provide a description of where the individual wants to live.
(f)	Community Services	Check prior community services utilized, including Name of PSH provider, type of voucher, and services received through Office of Citizens with Developmental Disability (list)
(g)	Prior Nursing Home Placement	Provide information on prior NF placement as appropriate; include name of facility, dates of residence, and reason for leaving as available from individual and/or family
(h)	Needs	From the evaluator's perspective, indicate the individual's needs that will allow the person to remain in the community. Include treatment, services, and/or resources needed for the person to live successfully in the community,

Learning/Working and Functional Status

XVI	Learning/Working and Functional Status	
(a)	Employment/Education/ Rehabilitation	Complete sections as noted. Include source of income, estimated monthly income, military income and status, whether the individuals has difficulties related to reading and writing, indicating estimated literacy level, and whether or not employed within the last year (yes/no). If yes, indicate the type of work performed. Identify any assistive devices being used by the individual Include additional comments when necessary.
(b)	Current Status & Functioning	Place an "X" in the degree of functional impairment for each ADL/IADL ranging from no impairment to total assistance. Provide a brief explanation for how determined and whether or not the impairment is expected to improve.
	Degree of Impairment	• No Impairment: No issues with Activities of Daily Living or Independent Living Skills • Supervision: Needs prompting, directions or instructions • Limited Assistance: Needs someone to help with getting a particular need met. • Extensive Assistance: Lacks ability meet needs without assistance. Needs almost total assistance with meeting needs. May only be able to do one ADL or IDL with limited support/assistance. • Total Assistance: Lacks ability to meet any of his/her needs. Rely totally on someone else to meet his/her needs.
	Comments	Discuss whether the impairments are due to his/her current illness or to his/her mental illness. Describe if the individual requires assistance or total dependence of someone else to complete. Identify what assistance the person needs.
(c)	Functional Abilities	Complete as a narrative of strengths, skills, and aptitudes and how these can help maintain or improve the current level of functioning and assist in maintaining the individual in community/least-restrictive setting.

Current Status

XVII	Mental Status Examination	Check all that apply, providing comments to clarify any issues not clearly addressed in check boxes above. Describe the behavior observed or reported; providing additional information regarding thought content and suicidal/homicidal ideation if checked. If suicidal/homicidal, be sure to explain the threat, suicide attempt or plan, including dates and/or how long ago the suicide/homicide event occurred.

PASRR LEVEL II Independent Behavioral Health Comprehensive Evaluation - Instructions

XVIII	Mood and Behavioral Assessment .	Assess if the individual has had an episode of significant decline to their psychiatric status that resulted in a behavior listed in this section within a set timeframe (30 days, 31 – 90 days, and if present in last 7 days). Indicate if an effective strategy has been identified to help manage these symptoms (yes/no); Describe what the individual has utilized in the past to assist with managing symptoms. Describe what can be utilized to assist the individual in managing his/her symptoms. Describe what warning signs the individual or the individual's family are able to identify prior to the person decompensating. (identify the source of this information) Summarize mental status including behaviors, intellectual functioning, cognitive functioning and reality testing.
XIX (a) (b) (c) (d) (e)	Risk Assessment Risk of Harm to Self Risk of Harm to Others Risk of Harm to Self or Others Rating Recipient Safety and Other Risk Factors Individual preference to address risk factors	Assess potential risk of harm to self or others, including patterns of risk behavior and/or risk due to personality factors, substance use, criminogenic factors, exposure to elements, exploitation, abuse, neglect, suicidal or homicidal history, self-injury, psychosis, impulsiveness, etc. Note if placement in a nursing home would cause risk to self or others. Check all that apply, providing a description as appropriate including. Check all that apply, providing a description, noting if risk is high. From LOCUS Risk of Harm Evaluation Parameters; if extreme risk, indicate what it is evidenced by. Check all that apply, providing a description. Describe individual's preferences and desires for addressing risk factors including their plan to address symptoms or to receive treatment and their willingness to seek help
XX (a) (b) (c)	Cultural and Language Preferences	As indicated by the individual. Religious belief or religious affiliation Culture belief or ethnicity Language preference: preferred language or other language spoken
XXI	Principal Diagnoses	List all mental health diagnoses. Identify the source of the diagnosis.
XXIII	Identified Needs	Identify services the individual, family and/or staff indicate the person would benefit from. This includes living situation, medical services, mental health services, supportive/recreational supports, substance use treatment/interventions, assistance with income or legal issues. Provide a description for all items checked including referrals to other agencies or community programs not listed. The individual's needs will be the focus of clinical attention. Including but not limited to those housing, medical, social, recreational, substance use, financial, and legal items listed above.
	Services the Recipient would benefit from	Identify what services the individual would benefit from based on his/her medical needs as recommended or identified by his/her treating medical

		physician or medical staff. Check all that apply, providing a description and/or additional information as applicable.
	Comments	Provide a thorough summary that speaks to the need for community based or NF Placement, including any additional needs not covered previously. The summary can address: • The central theme(s) apparent in the presentation of the person served • Histories and assessments (medical, disability, psychosocial, spiritual, or vocational), with special emphasis on potential interrelationships between sets of findings. • The perception of the person served of his or her needs, strengths, limitations, and problems. • Clinical judgments regarding both positive and negative factors likely to affect the person's course of treatment and clinical outcomes after discharge. • Recommended treatments, including any special assessments or tests, as well as routine procedures (e.g., laboratory tests). A general discussion of the anticipated level of care, length, and intensity of treatment and expected focus (goals) with recommendations." • Include any potential risk to the individual or other residents if placed in a nursing facility.
	Signature	Evaluator's printed name, signature license number, and date evaluation was completed.
Dementia Addendum		
	Dementia Addendum	Describe the individuals decline in everyday functioning such as their ability to fulfill responsibilities: interaction with other, and their capacity for self-care over a period of time. Identify as many areas as possible, identifying their level of impairment (no impairment, some impairment, major impairment, total impairment, or not applicable) over the 5 year timeline in order to demonstrate (as appropriate) the decline in functioning over time.
	Level of functioning	Describe in detail how the current level of functioning is different from best-sustained level of functioning.
	Decline in Functioning	Describe in detail the timelines of the person's decline in functioning, including how the person's level of functioning or ability to meet his/her needs is different from when they were able to meet their needs more independently.
MCO Section		
	Completed by the MCO Recommended Placement	MCO staff completes, indicating all as appropriate: MCO has reviewed the evaluation and it is complete Based on review, NF appears appropriate Based on review, NF does not appear appropriate; the person can be served in: a more restrictive setting or ales restrictive setting Check the setting that is the least restrictive setting for the individual considering their medical and behavioral health needs and the services available to meet those needs.
	History of Behavioral Health Claims	Indicate if the MCO shows a history of behavioral health claims in the past two (2) years (yes/no), checking all that apply

	Recommended Services	Check all that are recommended; ensuring eligibility/availability for individual. These services are provided by the state and not part of the NF standards for payment. If other, please clarify.
	Other (with explanation)	Any additional services not listed that the individual would benefit from. Example: referral to My Place Louisiana (MFP) or other services needed and not listed.
	Plan of Case Management	Provide detailed plan for providing case management services
	Additional Service Recommendations	Identify and describe other additional services needed and that will be provided to assist the individual with being able to maintain the person in the least restrictive setting.
	Signature	Name of MCO staff (printed and signed), position title and date reviewed.