Washington State Department of Social & Health Services
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DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: PASRR COMMUNICATIONS PROTOCOL POLICY 16.02

Authority:	42 CFR §483 Subpart C Chapter 388-834 WAC	*Preadmission Screening and Resident Review (PASRR)*
Reference:	DDA PASRR Manual	This manual is accessible via the DSHS DDA SharePoint website only.

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 an 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. This 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 Offices.

DEFINITIONS

Client, for PASRR purposes, means a person who has been confirmed to have an 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 to complete PASRR assessments and store PASRR data.

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

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

POLICY

To ensure timely receipt of nursing services, DDA Field Services Offices must maintain a plan for assignment and completion of PASRR assessments within established timeframes. The Regional Communication Plan will be reviewed at least annually and updated, if necessary.

PROCEDURES

A. DDA Field Services staff must communicate to the PASRR team immediately according to the Regional PASRR Communication Plan (this link is available on the DSHS DDA intranet website only) if he or she learns that:

1. A client has been hospitalized;

2. There has been a significant change in a nursing facility client's condition;

3. A client has been referred to, or is seeking placement in, a nursing facility;

4. A nursing facility client has requested information about additional services or about transitioning to a community setting;

5. A request for completion of a PASRR or a DSHS 14-300, *Level 1 Pre-Admission Screening and Resident Review (PASRR)* form is received;

6. A client is being discharged from a nursing facility; or

7. A hospital, nursing facility, or a potential client has called with questions about the PASRR program. (Individuals with an intellectual disability or a related condition, as defined in C.F.R. Sec. 483.102, who are referred for nursing facility care are eligible for PASRR. This may include individuals who do not meet DDA eligibility.)

B. The PASRR Regional Coordinator must:

1. Maintain a list of specific staff, by title, who will receive incoming PASRR communication in the PASRR Coordinator's absence.

2. Ensure that regional staff are instructed in the Regional PASRR Communication Plan and have access to the plan.

3. Ensure designated staff:

   a. Daily check incoming faxes for PASRR referrals; and

   b. Transfer calls related to PASRR according to the Regional PASRR Communication Plan.

4. Assign a trained assessor to complete the PASRR Level II determinations prior to nursing facility (NF) admission when he or she receives a PASRR referral for a new admission. The PASRR Regional Coordinator must assign the assessor no later than two (2) business days after the Level I date.

   a. When possible, the PASRR Assessor will complete the Level II evaluation prior to the NF admission and distribute to the client, guardian or Necessary Supplemental Accommodation (NSA), discharging hospital, nursing facility, and treating physician.

   b. If the PASRR Assessor is unable to complete the Level II evaluation prior to the NF admission, he or she will complete the Notice of PASRR Determinations and Planned Action Notice (PAN) and distribute to the client, guardian or NSA, discharging hospital, nursing facility, and treating physician. In this case, the Level II evaluation must be completed no later than thirty (30) calendar days after the Level I date.

5. Assign a trained assessor to complete the Level II determination as soon as possible if he or she receives a PASRR referral for a significant change of condition, but no later than seven (7) calendar days after the Level I date.

   a. When possible, the PASRR Assessor will complete the Level II evaluation within seven (7) calendar days and distribute to the client, guardian or NSA, nursing facility, and treating physician.

   b. If the PASRR Assessor is unable to complete the Level II evaluation within seven (7) calendar days, she or he will complete the Notice of PASRR Determinations and PAN and distribute to the client, guardian or NSA, nursing facility, and treating physician. In this case, the Level II evaluation must be completed within thirty (30) calendar days of the Level I date.

6. Provide general (not client-specific) PASRR information to DDA staff, hospitals, NF staff, and service providers.

7. Assure that the regional PASRR team provides outreach and training to regional hospitals and NFs as needed.

8. Schedule and facilitate monthly PASRR team meetings.

9. Assist PASRR Assessors as needed to ensure timely provision of specialized services, and include Regional Employment Specialists in discussions and correspondence regarding vocational or community access services.

10. Inform PASRR Program Manager immediately of any questions, concerns, or unusual incidents involving the PASRR Program, PASRR clients, or service providers.

C. The PASRR Assessor must:

1. Complete assigned tasks under B.4. and B.5. above;

2. Act as point-of-contact for all client-specific questions or concerns from NF staff;

3. Update DDA PASRR Management System (DPMS) with any new client information, such as death or discharge dates;

4. Act as liaison between client, representative, Roads to Community Living (RCL), case resource manager (CRM), NF staff, and service providers;

5. Review service plans and reports from service providers to assure that specialized services are appropriate and person-centered;

6. Work with service providers and, for county services, the Regional Employment Specialist for any changes needed to specialized services;

7. Receive copies of NF care plans and any professional evaluations requested as part of the PASRR Level II process; review these care plans to confirm that identified needs are being met and follow up as needed; upload recommendations to DPMS; and follow up with NF if reports are not received within thirty (30) days of request; and

8. Document all PASRR activities in the Service Episode Record (SER) and forward SER report weekly to NF for inclusion in client records.

D. The Regional Employment Specialist must:

1. Collaborate with the PASRR Assessors when employment or community access information is needed.

2. Communicate all county services information pertinent to PASRR to the PASRR Assessors.

3. Participate in all discussions or correspondence regarding vocational or community access services.

E. The Roads to Community Living (RCL) Resource Manager must:

1. Review the RCL program with individuals who are referred by the PASRR team and enroll eligible individuals in the RCL program if they are interested in moving to the community;

2. Develop a person-centered transition plan for the individual to move to the community and to identify RCL enhancements;

3. Participate in discussions or correspondence regarding community transition and RCL enhancements; and

4. Refer individuals to providers for community-based services.

F. The DDA Case or Resource Manager must:

1. Review DDA programs and services with individuals who are referred by the PASRR team if they are interested in moving to the community and are not eligible for RCL;

2. Complete any required assessments to determine program eligibility; and

3. Refer individuals to providers for community-based services.

EXCEPTION

Any exception to this policy must have written prior approval from the Deputy Assistant Secretary.

SUPERSESSION

None.

Approved: */s/ Donald Clintsman* Date: June 16, 2017
Deputy Assistant Secretary
Developmental Disabilities Administration