PASRR Screening for Mental Illness in Nursing Facility Applicants and Residents

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1. Executive Summary

Medicaid regulations require States to maintain a Preadmission Screening and Resident Review (PASRR) program to screen nursing facility applicants and residents for serious mental illness. The purpose of PASRR is to assess, through progressive screening, whether applicants for nursing facilities have mental illness or retardation, and if the nursing facility is an appropriate placement. The first test, Level I, screens for potential mental illness. All those who test "positive" must receive a more in-depth screen, Level II, which more accurately identifies mental illness and assesses whether the individual needs specialized services and nursing facility level of care.

The program's intent is to ensure that individuals are placed in the most appropriate setting and have access to specialized mental health services where appropriate. A number of recent studies have questioned the efficacy of the PASRR process in identifying individuals with mental health needs. Many (for example, SSWLHC, 1995) assert that the program unnecessarily delays nursing facility placement for individuals with no psychiatric needs. In the absence of existing studies examining these issues at both the State and nursing home level, the current study attempts to fill an important gap.

The first phase of this study involved a review of the existing literature on PASRR and of the mental health services for those in nursing facilities. That review was published as a Substance Abuse and Mental Health Services Administration (SAMHSA) separate report, Screening for Mental Illness in Nursing Facility Applicants: Understanding Federal Requirements (Linkins et al., 2001).

The current report outlines the findings from the second phase of the study, which involved a national survey of the relevant agencies in all 50 States and the District of Columbia to determine how they have organized and administered Federal requirements under PASRR. The second phase of the study also included case studies of four States, which were selected to include each of the entities that conduct Level II screens: private mental health agencies, community mental health centers, individual mental health practitioners, and referring agencies or State agencies. In each State, a total of six nursing homes were selected, with three located in an urban county and three located in a rural county. In each of those 24 nursing facilities, the administrators were interviewed about the PASRR process, and the medical records for the nursing facility residents were reviewed. In two of the four States, clinical interviews were conducted with a total of approximately 50 nursing facility residents.

National Survey Findings

- States have pursued several different courses in designating State agency responsibility for administration of PASRR. Approximately half (27) of the States divide PASRR responsibilities among Medicaid agencies and State mental health authorities (SMHAs). In four States, three agencies maintain direct involvement in the Level I or Level II screening process. In 13 States, either the Medicaid agency or the SMHA (but not both, although both have required responsibilities) is involved in PASRR and works with a third State agency. Most States do not report adequate oversight and tracking mechanisms for PASRR.
- States vary, as is permitted, in their designation of entities that can conduct Level I assessments. Level I screens are conducted by nursing facilities in six States, by referral sources (e.g., acute care facilities, community-based programs) in 10 States, and by a combination of the nursing facilities and referral sources in 16 States. Eight States contract out Level I screening responsibilities, while 11 States have Level I screens completed by State agencies, such as Medicaid and aging authorities.
- Federal statute requires that Level II assessments be completed by an independent entity other than the SMHAs. Nursing facilities may not conduct Level II screens. The majority of States (44) contract with mental health entities to conduct Level II assessments. Specifically, 17 States contract with private mental health agencies (e.g., managed behavioral health companies), 18 contract with community mental health clinics or other public mental health agencies, and 9 contract with individual mental health practitioners. The remaining States have the referring agency conduct Level II screens (three States) or delegate responsibility to a State agency (four States) other than the mental health authority.
- With the elimination of the annual resident review requirement in 1996, States were required to develop criteria and procedures for identifying when nursing facility residents experience a significant change in condition to trigger a Level II review. While most States have developed acceptable procedures for identifying significant changes in condition (e.g., use of the Minimum Data Set [MDS], specific behavioral/functional criteria, requirements for nursing facilities to notify the State), there is evidence that rates of compliance with this requirement may be low. This information is consistent with the finding of the PASRR study conducted by the Office of the Inspector General (OIG) (2001).
- While respondents faulted PASRR as currently implemented, many indicated that PASRR could be more effective with improved training and oversight. Most rated PASSR as doing a "good" job of meeting its main policy goals of identifying individuals with serious mental illness, screening appropriateness for nursing facility care, and ensuring provision of specialized services. About half also reported that it has positively affected the type, amount, and quality of mental health services in their State.

In-Depth Case Study Findings

- Across the four States, percentages of Level I screens found in medical records ranged from 71 to 93 percent. Level II screens, which are required to be in medical records, were far less prevalent in medical records (ranging from 0 to 14 percent). Even fewer medical records (<10 percent) had any record of a resident review (clinical or medical chart evaluation by a health professional), which is of concern because 53–81 percent of the residents sampled had a diagnosable mental illness at the time of review, and 43–61 percent had a dementia-related condition.
- In the two States, clinical interviews were conducted with a sample composed of residents likely to have mental illness. This subset of residents did not receive a Level II Screen as required or services other than medication management and some case consultation.
- Very few of the interviewed residents received psychological testing/evaluation or the services of a psychologist, and no residents received individual or group therapy, case management, psychosocial rehabilitation, behavior management, psychoeducation, day treatment, outpatient, or other mental health services. This finding suggests that PASRR may not be meeting its second important purpose of ensuring that needed mental health services are provided to nursing facility residents.
- Interviews with nursing facility staff revealed that PASRR was not perceived as an effective tool for properly identifying and treating mental illness in the elderly population. Very few facility respondents rated PASRR as doing an "excellent" job in achieving desired outcomes. In two States, the majority of nursing facility respondents rated PASRR in the "good" to "fair" range. Ratings in the other two States were slightly lower, with most respondents rating PASRR in the "fair" to "poor" range. Ratings were even lower when respondents were asked about PASRR's ability to ensure the provision of specialized services. Few respondents said that PASRR was an administrative burden.

II. Introduction

A. Purpose and Rationale of Study

Congress enacted the Preadmission Screening and Annual Resident Review (PASARR) program to prevent the inappropriate admission and retention of people with serious mental disabilities in nursing facilities. The program was enacted as part of the Nursing Home Reform Act under the Omnibus Reconciliation Act (OBRA) of 1987, as amended by OBRA 1990, 42 USC 1396r(e)(7).

Originally, the program included an annual resident review and was referred to as the Preadmission Screening and Annual Resident Review (PASARR) program. Under the Balanced Budget Amendment (BBA) of 1996, P.L. 104–315, or 42 USC 1396r, the requirement for an annual resident review was eliminated and replaced with a requirement to screen when "there is a significant change in physical or mental condition." The current abbreviation of PASRR is used to refer to the program throughout this paper. It should be noted that PASRR screens for serious mental illness and mental retardation, with requirements for each, but this report concerns only PASRR screening for serious mental illness.

Since the program began, many organizations have expressed concerns about its value and effectiveness. For example, the Society for Social Work Leadership in Health Care, the American Psychiatric Association, and the American Association for Geriatric Psychiatry conclude that while the program's goals are laudable, PASRR can create logistical barriers for persons requiring nursing facility placements, and it does not necessarily ensure access to appropriate mental health services.

Research also highlights ongoing concerns that PASRR may not be working as originally intended. The following studies underscore the need to take a closer look at how well the program is working. Results from one study indicate that nursing facility residents with mental health needs often do not receive needed mental health services, and a significant minority are not placed in alternative placements when appropriate (Snowden, Piacitelli, & Koepsell, 1998). Similarly, other researchers have found that both clinicians and consumers are likely to view elderly nursing facility residents with serious mental illness as more appropriately served in community settings as long as they are not suffering from severe dementia (Bartels, Miles, Dums, & Levine, 2003).

Two additional investigations have examined PASRR implementation and effectiveness more directly. In 1996, the Bazelon Center for Mental Health Law reported on results from a national survey of State Medicaid agencies. The Bazelon Center for Mental Health Law (Bazelon) found tremendous State variation in definitions, responsibility, and personnel qualifications for conducting PASRR screens, and in the type and availability of mental health services offered in nursing facilities and alternative placement options. Even more recently, the U.S. Department of Health and

Human Services (DHHS), Office of the Inspector General (OIG) completed an investigation of PASRR involving site visits to five States, a national survey of PASRR agencies, and analysis of MDS and Medicaid claims data (OIG, 2001).

In examining the mental health treatment of younger Medicaid beneficiaries with a serious mental illness residing in nursing facilities, OIG found that (1) many State PASRR programs are not in compliance with Federal requirements and do not ensure that mental health needs are assessed; (2) States may violate Federal intent when defining "specialized" services as 24-hour, inpatient psychiatric care; and (3) many PASRR systems function with little oversight from State and Federal authorities. OIG specifically recommended that the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS) work collaboratively to better define their roles in overseeing and supporting States in implementing PASRR programs.

In addition to these studies, statutory changes and judicial rulings also signal a need for a closer examination of how well PASRR is working. While the 1996 BBA eliminated the requirement for States to conduct annual resident reviews, compliance with the provision to screen when significant changes occur has not been evaluated.

The 1999 Olmstead Supreme Court decision is also prompting States to reexamine how decisions are made about institutional and community-based placements for disabled populations, including people with mental illness. The decision mandates that States "provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate." States must take into consideration their resources and the needs of other people with disabilities in making such determinations. As part of this reexamination, some States are considering changing their approach to administering and monitoring PASRR.

To address these ongoing concerns, this study explores how States implement PASRR and examines how the program has affected the identification and delivery of mental health services to people with serious mental illness in nursing facilities. Phase I of the study involved a comprehensive literature and legislative review of PASRR and mental health services for persons in nursing facilities. This literature review was published as a separate SAMHSA report, *Screening for Mental Illness in Nursing Facility Applicants: Understanding Federal Requirements* (Linkins et al., 2001).

The current report presents findings from Phase II, which had two parts. The first part of Phase II involved a national 50-State survey of PASRR agencies examining State experiences with PASRR implementation and outcomes. The second part of Phase II involved in-depth studies of four States, conducted to understand how and how well the PASRR process works at local levels. Interviews were conducted with nursing facility staff, and some clinical interviews were conducted with nursing facility residents for the in-depth studies. Medical charts were also reviewed.

B. Report Organization

The remaining sections of this report are organized as follows:

- **Section III: Overview of the PASRR Process** briefly highlights the program's history, describes the PASRR process,

and discusses current policy issues.

- **Section IV: Methodology** reviews core research questions and methodology used for the study.
- **Section V: National Survey Findings** presents findings from the national survey of State mental health authorities (SMHAs) and Medicaid agencies.
- **Section VI: In-Depth State Study Findings** integrates findings from multiple data sources, including interviews with nursing facility staff, reviews of resident medical records, and clinical interviews with residents.
- **Section VII: Conclusions** presents a summary of findings from the national survey and State studies to highlight ongoing issues and concerns regarding PASRR operation and administration.

III. Overview of the PASRR Process

This section presents an overview of the history of PASRR, details regarding the screening process, and current issues concerning the implementation and administration of the policy.

A. Background

1. History of the PASRR Program

Congress created the PASARR program under the Omnibus Budget Reconciliation Act (OBRA) of 1987 to address concerns that many people with serious mental illness or mental retardation were inappropriately placed in nursing homes. At the time, Congress was becoming increasingly aware that some States were using nursing facility placements as a way to reduce overcrowding in State facilities for people with serious mental illness. In the decade leading up to the program's creation, nursing facilities typically did not have adequate resources to provide appropriate care for this new category of residents (Emerson Lombardo, 1994; GAO [General Accounting Office], 1982).

Congress responded to these concerns by directing CMS and GAO to investigate nursing home quality. In response, CMS funded an Institute of Medicine (IOM) study that reported widespread problems and recommended strengthening Federal regulations to address patient rights, quality of care, and quality of life in nursing facilities (IOM, 1986). In 1987, GAO issued a report that corroborated IOM findings, indicating that more than one third of U.S. nursing homes were operating at a level below minimum Federal standards. The report cited evidence of untrained staff, inadequate provision of health care, unsanitary conditions, poor-quality food, unenforced safety regulations, and many other problems related to nursing facility quality and safety.

Accumulatively, these reports spurred Congress to enact nursing home reform legislation under OBRA in 1987. In addition to detailed requirements concerning patient rights, patient assessments, and staffing criteria, the legislation also included several provisions that pertained directly to the problem of inappropriate placement and inadequate treatment of people with severe mental illness in nursing facilities. These provisions, revised and updated in the Code of Federal Regulations in 1992, included regulating the use of antipsychotic medications and physical restraints and established the Preadmission Screening and Annual Resident Review (PASARR) program. The purpose of these provisions was to determine whether or not individuals have a serious mental illness, require specialized mental health services, and need the level of care provided by a nursing facility. However, the requirement for an annual resident review was eliminated by the BBA of 1996 and replaced with a

requirement to screen when nursing facilities determine that "there is a significant change in physical or mental condition."

2. How the PASRR Process Works

The process of screening and determining if nursing facility services and specialized mental health services are needed by nursing facility applicants and residents is called the Preadmission Screening and Resident Review (PASRR) program. PASRR is a required component of each State's Medicaid plan. While SMHAs have specific responsibilities under Federal statute and regulations, and some responsibilities may be delegated to other State agencies (e.g., aging administration, Department of Health), State Medicaid agencies bear the ultimate responsibility for PASRR program operations, as illustrated in Exhibit 1.

State PASRR programs typically are composed of two main parts: Preadmission Level I prescreen (for potential mental illness) and Level II screen (PAS) for verification of serious mental illness and determination of the need for specialized services and the services of a nursing facility. Level II evaluations may also include a post-admission assessment called a Level II resident review, if and when a patient's condition changes.

Exhibit 1: Responsibility for Oversight of PASRR Screens

PASRR Screens	Responsibility	Eligible To Conduct Screen
Level I Screen	State Medicaid Agency: oversight	All involved parties, including nursing facilities, SMHA, or an independent entity
Level II Preadmission Screen	State Medicaid Agency: oversight SMHA: determinations for mental illness that nursing facility is appropriate and specialized services are needed	Independent entity (other than SMHA) without ties to a nursing facility
Level II Resident Review (change in condition assessment)	SMHA: determination, after nursing facility identifies change, that nursing facility is appropriate and specialized services are needed	Independent entity (other than SMHA) without ties to a nursing facility

Level I Screen. To identify nursing facility applicants who might have a serious mental illness, Medicaid regulations require States to conduct a Level I screening of all prospective nursing facility applicants. Federal regulations provide no rules on the tools used or the personnel who implement the Level I screenings. The screens may be conducted by the State Medicaid agency, nursing facilities, hospitals, physicians, or any other entity specified by the State. The screens typically involve a record review and/or clinical patient interview to determine whether or not there is evidence of a serious mental illness requiring administration of a Level II screen. Patients being readmitted to a nursing facility or being transferred from one nursing facility to another are not considered new admissions and are not required to undergo preadmission screening.

Level II Preadmission Screen (PAS). Based on Level I screen results, States are required to administer a more extensive preadmission screen—referred to as the Level II screen—to individuals who are suspected of having a serious mental illness. Level II assessment typically involves an in-depth clinical evaluation by a trained mental health professional to verify whether or not an individual has a serious mental illness. For PASRR purposes, mental illness is defined in 42 CFR 483.102(b)(1) as one of the serious mental illnesses listed. The regulation refers to one particular version of the *Diagnostic and Statistical Manual of Mental Disorders*, published in 1987 (*DSM-III-Revised*), rather than specifying the most current edition of the DSM. This way, the population covered by the particular regulation will not change even if the definition of serious mental illness changes in subsequent DSM editions.

If the Level II screen is positive for serious mental illness, a two-pronged determination must be made as to whether or not the individual requires (a) specialized mental health services and (b) nursing facility services (specific to the facility where application is made). The Level II screening may be omitted for groups of individuals who belong to certain advance determination categories, such as individuals with a primary diagnosis of dementia or those being discharged from an acute care facility who require convalescent care for less time than 30 days.

Although responsibility for determinations and oversight officially resides with the SMHA, determinations must be based on an independent evaluation conducted by an entity designated by the State Medicaid agency other than the SMHA or a nursing facility. The SMHA (or designated State agency other than a nursing facility), however, is held responsible for ensuring the screenings are conducted and for using the results to make a determination.

If the State determines that an individual with mental illness requires nursing facility services and also requires specialized services, the State Medicaid agency must provide or arrange for the needed specialized services. Federal regulations allow States to determine what mental health services specifically constitute specialized services. Furthermore, the Medicaid statute requires nursing facilities to provide services "not otherwise provided or arranged for (or required to be provided or arranged for) by the State." This requirement is interpreted in regulations to include all services provided by the facility under the nursing facility's per diem rate that are of lesser intensity than the specialized services provided by the State.

***Level II Resident Review (RR) Screens:* Change in Condition Assessment.** Current law (since 1996) requires nursing facilities to notify the SMHA (or appropriate State agency) promptly after a significant change in the physical or mental condition of a resident with serious mental illness. Regulations further specify that an independent agency must conduct a Level II screen to evaluate such residents, and the SMHA must determine whether their placements continue to be appropriate, as well as which, if any, specialized services are needed.

B. Current Issues and Concerns Regarding PASRR

Advocacy organizations representing mental health and aging communities, including the American Psychiatric Association, the American Association for Geriatric Psychiatry, AARP, the Alzheimer's Association, the Bazelon Center for Mental Health Law, and the Society for Social Work Leadership in Health Care, continue to have concerns regarding the effectiveness of PASRR programs in achieving intended policy goals. These concerns have been summarized in SAMHSA's 2001 policy report (Linkins et al., 2001) and include the following:

- **There is a lack of clear definitions in the legislation.** Although diagnosing serious mental illness is subject to Federal minimum requirements, States are allowed to establish their own definitions of serious mental illness and administer their own instruments to screen for suspected mental illness. As a result, an individual might be identified as experiencing a serious mental illness in one State but not in another. Similarly, with no standardized definition for "specialized services," the mental illness may be addressed differently across States. State definition of specialized services as acute inpatient care (not in a nursing facility) is a significant concern as this definition eliminates the individualized treatment services that the regulations establish for nursing facility residents with mental illness or mental retardation. Some States limit these services to acute inpatient care, while others include a combination of inpatient and community-based services (OIG, 2001; Bazelon, 1996).
- **Funding PASRR screens, specialized services, and alternative placements is challenging for States.** From the beginning, States have expressed concerns about the costs associated with implementing PASRR (Emerson Lombardo, 1994). If individuals require specialized services to treat their mental illness, the State Medicaid agency ultimately is responsible for providing or arranging for provision of those specialized services. The Medicaid statute requires nursing facilities to provide treatment and services of lesser intensity than specialized services. To prevent duplicate payment, no Federal financial participation is available to reimburse "special services" that are being paid for as nursing facility services. However, Federal financial participation is available for specialized mental health services that are State plan services (other than nursing facility services). The lack of specific definitions of specialized services in Federal law or regulations has resulted in considerable confusion over which services must be provided by States and which services must be

provided by nursing facilities. If a State chooses to limit its definition of specialized services to reduce the scope of this unfunded mandate, it shifts a greater burden on nursing facilities to provide or arrange for psychiatric services. If PASRR determinations recommend against nursing facility placement, finding and funding alternative placements becomes the responsibility of the State, as this is not a PASRR function.

- **Individuals with dementia, including Alzheimer's disease and related disorders, present unique challenges for nursing facilities.** A recent article by Cohen, Hyland, and Kimhy (2003) concluded that instituting a mandatory depression screen for nursing facility residents with dementia can increase the diagnosis and psychotropic treatment of individuals with both dementia and depression. Nevertheless, the statutory definition of mental illness (for PASRR) specifically excludes persons with dementia-related conditions, unless their primary diagnosis is severe mental illness. Because nursing facilities are not required to conduct Level II screens on these individuals, statutory exemptions may have the unintended effect of failing to identify the need for specialized and other mental health services among individuals with dementia or Alzheimer's disease (Emerson Lombardo, Fogel, Robinson, & Weiss, 1995). Identification and provision of mental health service needs for this population becomes the de facto responsibility of the nursing facility.
- **There are limited resources for monitoring and enforcing PASRR.** With few resources to offer technical assistance and monitor States, and with limited statutory penalties except closing a facility, denying payment, or issuing a fine, CMS has had difficulty enforcing PASRR. Consequently, advocates and policymakers suspect that PASRR is not having the full intended effects (Sherrell, Anderson, & Buckwalter, 1998; Borson, Loebel, Kitchell, Domoto, & Hyde, 1997; Bazelon, 1996; Marek, Rantz, Fagin, & Krejci, 1996).
- **There is inefficient utilization of the expertise of mental health professionals.** The issue of which doctors or other professionals provide mental health services to nursing home residents remains variable. Some researchers have found that much of psychiatrists' and other mental health professionals' time is dedicated to evaluation and medication management, leaving them unable to provide therapy and other modes of treatment (Emerson Lombardo et al., 1995). Others charge that the underlying problem restricting the utilization of psychiatrists and psychologists is the low reimbursement rates by Medicaid and Medicare. Furthermore, there is concern that nursing facility staff lack adequate knowledge of mental health issues. Unless staff members are trained in managing mental health and behavioral issues, they will be unable to provide an environment conducive to each resident's mental health. PASRR nursing facility determination is facility-specific, and a determination that a nursing facility is needed should not actually be made if the facility does not have staff adequately trained in meeting mental illness needs.
- **There are delays in placement.** Some research has indicated that hospitals and

nursing facility staff are concerned about delays in placement caused by the PASRR screening process (SSWLHC, 1995). According to PASRR regulations, individuals cannot be placed in nursing facilities until after the PASRR screens have been completed. However, the Society for Social Work Leadership in Health Care survey indicates that an individual requiring both Level I and Level II screens can be forced to wait up to 3 weeks for a final determination. Such delays in treatment are not only detrimental to the individual desiring placement, but are also costly in delaying referral from expensive acute care facilities.

IV. Methodology

This section presents research questions and describes the overall assessment approach used to conduct the study. An advisory panel of experts (see Exhibit 1 in Appendix B) representing organizations in the fields of mental health, aging, and long-term care provided guidance on all aspects of study methodology.

A. Study Goals and Research Questions

This project addressed three main research goals: (1) understand State and nursing facility procedures for PASRR implementation; (2) gauge the impact of PASRR on achieving intended policy goals; and (3) identify implementation issues of concern to States. Specific research questions and subquestions included the following:

1. How are States and nursing facilities implementing PASRR?

a. How is PASRR organized and administered at the State level?
b. How and how well are States and nursing facilities implementing PASRR Level I and Level II screening procedures?
c. How and how well are States and nursing facilities implementing PASRR change in condition assessment procedures?
d. How are States overseeing and monitoring PASRR implementation?

2. How has PASRR affected intended policy goals?

a. How has PASRR affected the identification of serious mental illness among nursing facility applicants and residents?
b. How has PASRR affected the availability and receipt of mental health services in nursing facilities?
c. How has PASRR affected screening for nursing facility level of care for nursing facility applicants and residents?

3. What issues have States and nursing facilities identified throughout PASRR implementation?

a. What has been the impact of PASRR on broader system issues, such as the availability of community-based alternatives to institutional care?
b. How do States and nursing facilities perceive PASRR?
c. What are State and nursing facility recommendations to improve PASRR?

The breadth and depth of these questions underscore the importance of obtaining perspectives from multiple stakeholders at the State and nursing facility levels. The resulting multilevel study design (described below) reflects this awareness.

B. Study Components

To gather relevant information on both State and nursing facility experiences with PASRR implementation and outcomes, a multilevel approach was used, consisting of a national survey of all 50 States and the District of Columbia, augmented by in-depth studies of 4 States. Qualitative and quantitative data were collected from multiple data sources using a variety of data collection tools. In the following section, these two study phases are described in more detail.

1. National Survey of PASRR Agencies

a. Data Collection Procedures and Tools

To obtain State-level perspectives from all 50 States and the District of Columbia, a survey was conducted of PASRR representatives from State agencies involved in PASRR administration. These respondents typically included Medicaid and SMHAs, but in some States, aging or health authorities responsible for administering PASRR Level I or Level II screens were interviewed. Individuals most knowledgeable about PASRR operations were identified and mailed invitation letters. Follow-up calls were made to schedule telephone interviews.

Interviews were conducted with at least one State PASRR agency in all 50 States and the District of Columbia, yielding an overall State-level response rate of 100 percent. In total, 47 interviews with SMHAs, 43 with State Medicaid agencies, and 5 with State aging or health agencies were conducted. Fourteen of these interviews were conducted jointly with multiple PASRR agencies. The majority of interviews were conducted by telephone; however, some individuals preferred to submit written survey responses.

Structured surveys were developed using a core set of questions, augmented by additional items tailored as appropriate to Medicaid, SMHAs, or other State agencies. To the extent possible, survey questions replicated questions from existing surveys, such as those used by Bazelon and OIG, to enable comparison and response validation. One survey version targeted agencies involved in administering Level I screens (e.g., Medicaid, aging/health authority), and the other targeted agencies typically involved in administering Level II screens (e.g., SMHA). The final "Medicaid" version consisted of 45 closed and open-ended questions, while the SMHA version consisted of 43 closed and open-ended items. Exhibit 2 displays content areas of the State-level interview protocols (for complete survey protocols, see Appendix C). Interviews lasted approximately 45–60 minutes. For States where a single State agency administers PASRR or when joint interviews with multiple PASRR agencies were conducted, the broader "Medicaid" version of the survey was used.

Exhibit 2: State-Level Interview Protocol

Interview Protocol: State Agency PASRR Representative
PASRR Implementation: Procedures. Included 21–23 questions on Level I/II screening process and outcomes, change in condition procedures, mental health service delivery, and the process of categorical determination.
PASRR Implementation: Oversight Responsibilities. Included six questions on State agency oversight responsibilities and nursing facility responsibilities.
Issues Identified From PASRR Implementation. Included 16 questions on PASRR design and impact on State agencies and the mental health system and the connection to Olmstead planning.

States were asked for additional information and documents using standard forms for such requests. States were also asked to submit PASRR policy and relevant programmatic documents and statistics on the number of Level I and Level II screens conducted in the past fiscal year. Forty-four States returned these data/document supplement forms.

2. In-Depth State Studies

a. Selection Criteria

To augment national survey findings and understand the PASRR experiences of nursing facility staff and residents at the local level, four States were selected for in-depth study.

State Selection Methodology. National survey findings indicated that the single greatest source of variation in PASRR implementation was the type of entity States designated to conduct the Level II PASRR screens. Four types of entities were used to conduct Level II screens: (1) private mental health agency; (2) public mental health agency; (3) individual mental health practitioners; or (4) independent State agencies and other sources. States were sorted by the four Level II PASRR screen types of entities and by geographic region (South, West, Midwest, and Northeast) to select the four study States. One State per type of entity was selected, ensuring that the four geographic regions were represented in the final selection of States.

Nursing Facility Selection Methodology. SAMHSA and CMS identified geographic variability (urban and rural) and variations in facility size as two key stratification criteria for selecting nursing facilities in each of the four States. Using the 2000 census for the urban area, the largest metropolitan statistical area (MSA) in each State was selected. For the nonurban area, a rural county not contiguous to the selected MSA was chosen. Within each urban and rural county, a stratified random sample (stratified by facility size) of three nursing facilities was drawn using the CMS Nursing Home Compare Database. Small nursing facilities were those with fewer than 60 beds, medium facilities had 61–90 beds, and large facilities had more than 90 beds.

Nursing Facility Resident Selection Methodology. For the medical record abstraction sample, the following three selection criteria were used to identify residents who might have a serious mental illness: (a) received a PASRR Level II screen;

(b) currently prescribed psychotropic medications from the following classes: neuroleptics, antidepressant, anxiolytics, or mood stabilizers; or (c) positive for any primary or secondary diagnosis of mental illness (not limited to severe mental illness). Residents meeting any of these three criteria were grouped together on a master list, from which up to 40 residents (depending on the size of the nursing facility) were randomly sampled for medical record abstraction. In two States, clinical interviews were conducted with a subset of residents drawn randomly from the medical record sample in each facility. This ensured that clinical interview information could be augmented with diagnostic, care plan, and treatment information collected through the medical record review. In each nursing facility (six per State), a random sample of 7–9 residents was drawn from the sample of 30–40 medical records for each facility. Residents were invited to participate in the study and underwent a process of informed consent. Only those agreeing to participate voluntarily in the study were administered the clinical interview. When residents refused to participate, another resident was randomly selected from the remaining list for replacement.

b. Data Collection Procedures and Tools

To recruit States for the in-depth studies, invitation letters were mailed to PASRR program administrators in the selected States. Letters described the proposed in-depth study and assured States of confidentiality. All four States approached agreed to participate in the study. After attaining agreement at the State level, the nursing facility sample was drawn according to the selection criteria described earlier. Introductory letters to selected nursing facilities were mailed, followed by telephone calls to secure facility participation. When facilities declined participation, the sample was redrawn. Data collection in each of the four selected States was completed from May through July of 2003.

Key Informant Interviews. A total of 24 key informant interviews were conducted with nursing facility administrators and staff from six nursing facilities in four States. To guide these interviews, a structured protocol, similar in content and organization to the State-level protocols described earlier, was developed. The final version consisted of 48 closed and open-ended questions (see Exhibit 3 for protocol content areas). Interviews lasted between 45 and 60 minutes.

Medical Record Abstractions. In 6 nursing facilities in each of the 4 States, resident medical records were abstracted for 30–40 nursing facility residents per facility, for a total of 786 records. An abstraction tool was developed to extract key information on PASRR documentation, resident background characteristics, medical and psychiatric history, psychotropic medications prescribed, mental health services received, and the number of acute care discharges (see Exhibit 4). These reviews yielded information that enabled the comparison of resident PASRR screen results with subsequent mental health treatment prescribed and delivered (including use of psychotropic medications).

Exhibit 3: Nursing Facility Staff Interview Protocol

Interview Protocol: Nursing Facility Staff
PASRR Process. Included 18 questions regarding respondent knowledge and perceptions about the PASRR process, including knowledge of change in condition procedures.
Prevalence of Mental Disorders in Nursing Facilities. Included seven questions collecting information on the number of residents with primary and secondary mental illness diagnoses.
Mental Health Services in Nursing Facilities. Included 13 questions regarding the availability and scope, utilization, and access barriers for the provision of mental health services in nursing facilities.
Organizational Changes. Included three questions regarding respondent perceptions of the impact of PASRR, including administrative burden, on the operation of the facility.
Communication With the SMHA. Included 11 questions capturing information on procedures used to communicate regarding a change in condition, arrangement of specialized services, State monitoring, and other regulatory requirements.

Exhibit 4: Medical Record Abstraction Tool

Medical Record Abstraction Tool
Background Characteristics. Captured information on resident demographics, referral source, and reason for admission.
Medical and Psychiatric History. Collected data on physical and mental health diagnoses at time of initial admission and currently.
PASRR Documentation. Captured information on whether charts contained Level I, Level II, and Resident Review screens and key outcomes from these forms.
Psychotropic Medications and Mental Health Services Ordered. Collected information on medications and services ordered at time of initial admission and currently.
Mental Health Services Received. Reviewed progress notes from the previous 30 days to identify mental health services residents currently receiving.
Acute Care Discharges. Recorded the number of times residents had been discharged to acute care facilities and for what reason (e.g., mental or physical health).

Clinical Interviews. In two States, clinical interviews were conducted in six nursing facilities with up to seven to nine nursing facility residents per facility. A total of 93 residents were interviewed. Clinical interviews involved a brief cognitive, psychiatric, functional, and quality-of-life assessment of nursing home residents with instruments that are commonly used and well validated on this population. These interviews yielded additional information about nursing facility residents' current clinical diagnosis and treatment profile as compared to their PASRR status. During clinical interviews, a dementia screen was administered first to screen out residents with significant cognitive impairment whose responses on subsequent interview tools would not have been valid. Interview tools are described in more detail below.

The **Blessed Orientation-Memory-Concentration (BOMC) Test** is a six-item instrument to screen for the presence of dementia. Total scores range from 0 (all items answered correctly) to 28 (all items answered incorrectly), with higher scores indicating greater impairment. Scores greater than 10 are consistent with dementia (Katzman et al., 1983).

The Brief Symptom Inventory (BSI) is a 53-item self-report inventory that asks people to use a 5-point scale to rate their level of emotional distress across a range of psychological experiences. There are nine primary symptom dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. There is also a global severity index. Higher scores indicate greater symptom severity (Derogatis, 1982).

The **Geriatric Depression Scale** is a 15-item questionnaire that assesses level of depression in older adults. It uses a series of yes/no questions. Affirmative responses are given a value of "1" and are tallied to create a composite score. Higher scores indicate more severe depression (Sheikh & Yesavage, 1986).

The **Short-Form Health Survey (SF-12)** is a 12-item survey that assesses perceived health and functional ability in physical and mental domains. It uses a combination of yes/no items and five-point Likert scales. A scoring algorithm is used to aggregate items into two composite scores (physical, mental), with lower scores reflecting more impaired health (Ware, Kosinski, & Keller, 1996).

The **Dementia Quality of Life Instrument (DQoL)** is a 29-item, 5-point scale assessing quality of life for individuals with mild to moderate dementia. It has five subscales: self-esteem, positive affect, negative affect, feelings of belonging, and sense of aesthetics. Each scale is scored separately, and the scale score is the mean of the items in that scale. The DQoL also includes an optional single item to assess overall quality of life (Brod, Stewart, Sands, & Walton, 1999).

V. National Survey Findings

This section reports on findings from a national survey of State agencies involved in PASRR administration. Sections A through C address the following three research questions:

1. How are States implementing PASRR? (Section A)
2. How has PASRR affected its intended policy goals? (Section B)
3. What issues have States identified through PASRR implementation? (Section C)

As described in Section III, the national survey achieved a 100 percent response rate. Because not every respondent answered every question, however, there is variation across individual item responses.

A. PASRR Implementation at the State Level

This section presents survey results related to State-level policies and procedures for organizing and administering PASRR programs, conducting Level I/Level II screens and change in condition assessments, and maintaining oversight of PASRR implementation.

1. Organization and Administration of PASRR

a. What State Agencies Are Involved in PASRR Administration?

State Agency Involvement in PASRR. Federal law and regulations articulate specific PASRR roles for Medicaid agencies and SMHAs. Medicaid agencies are required to include a PASRR program in their State plan and develop a written agreement with the SMHA detailing PASRR operations. In addition, State PASRR agencies can delegate only those functions for which they are responsible and must maintain overall oversight responsibility for those functions. Survey results indicated considerable variation in how States organize and distribute PASRR responsibilities across State agencies. Exhibit 5 shows the number of agencies involved in State PASRR screening activities.

State agencies were considered to be "involved" if they play an active role in administering or overseeing some aspect of the PASRR process. For example, a State agency that maintains direct oversight for tracking and reporting Level I outcomes would be considered "involved," while another that has a memorandum of understanding granting Level I tracking and reporting oversight to a different State agency would not.

In seven States, a single agency assumes the bulk of Level I and Level II screening responsibilities, with very marginal involvement from other State agencies.

Exhibit 5: State Agency Involvement (n=51)

Agency Involvement in PASRR	States
One agency: (Medicaid or SMHA)	7 (14%)
Two agencies:	
– Medicaid and SMHA	27 (53%)
– Medicaid, SMHA, and aging/health authority	13 (25%)
Three agencies: (SMHA, Medicaid, aging/health authority)	4 (8%)

Approximately half (27) of the States divide PASRR responsibilities across Medicaid and SMHAs. In 13 States, either the Medicaid or SMHA (but not both) is involved in PASRR and works with a third agency, typically the aging authority or another health authority (e.g., Department of Health). In four States, three State agencies maintain direct involvement in the Level I or Level II screening process. While the present study cannot assess the appropriateness of interagency delegation of tasks, it is clear that where the SMHA or State Medicaid agency are not substantially involved, those agencies cannot be in compliance with the unique responsibilities each has under Federal regulations.

State PASRR Agency Location. As shown in Exhibit 6, in nearly half (24) of States, agencies involved in PASRR administration are located within the same central agency (i.e., they are "centralized"). For example, many States locate the mental health authority and Medicaid in divisions under a single umbrella agency, such as a Department of Health and Human Services.

Exhibit 6: State PASRR Agency Location (n=51)

PASRR Agencies	Centralized	Decentralized
One agency: (n=7)	7 (14%)	—
Two agencies:		
–SMHA and Medicaid (n=27)	10 (19%)	17 (33%)
– SMHA or Medicaid and aging/health authority (n=13)	7 (14%)	6 (12%)
Three agencies: (n=4)	—	4 (8%)
Total	**24 (47%)**	**27 (53%)**

Exhibit 7: Entity Conducting PASRR Screens (n=51)

Entity Conducting Screen (n=51)	Level I	Level II
Nursing Facility and/or Referring Agency	**32 (63%)**	**3 (6%)**
– Nursing facility only	6 (12%)	—
– Referring agency only	10 (20%)	3 (6%)
– Nursing facility and referring agency	16 (31%)	—
Contractor	**8 (16%)**	**44 (86%)**
– Private agency/agencies	—	17 (33%)
– Individual private practitioners	—	9 (18%)
– Community mental health clinics (CMHCs) or mental health authorities	—	18 (35%)
State Agency (e.g., State Medicaid Agency, SMHA, Aging Authority)	11 (21%)	4 (8%)

b. How Do States Distribute PASRR Administrative Functions?

Entity Designated by States To Conduct PASRR Screens. Exhibit 7 displays the entities States designate to conduct Level I and Level II screens. Many States allow multiple entities to complete screens.

Level I Screens. Federal regulations grant States considerable flexibility in designating which entities can conduct Level I assessments. Level I screens are conducted by nursing facilities in 12 percent of States and by referral sources (e.g., acute care facilities, community-based programs) in 20 percent of States. Together, the majority (32) of States allow nursing facilities and referral sources to complete Level I screens. In States that allow nursing facilities to complete Level I screens, respondents typically described this as being part of the admissions process (i.e., nursing facility staff evaluate applicants before they can be admitted). Eight (16 percent) of States contract out Level I screening responsibilities, while in 11 States (22 percent), Level I screens are completed by State agencies, such as Medicaid and aging authorities.

Level II Screens. Federal statute stipulates that Level II assessments must be completed by an independent entity other than the SMHA, a nursing facility, or an entity related

to a nursing facility. The majority of States (44) contract with mental health entities to conduct Level II assessments. Specifically, 17 States contract with private mental health agencies (e.g., managed behavioral health companies), 18 contract with community mental health clinics or other public mental health agencies, and 9 contract with individual mental health practitioners. This suggests that some SMHAs may be improperly delegating this function.

Entity Designated by States as Responsible for Making Level II Determinations. In 43 percent of States, Level II final determinations are made at the State agency level based on results from an independent evaluation. However, in the majority of States (57 percent), whichever entity completes the Level II assessment—whether it is a contracted entity or independent State agency—is allowed to make the final determination as to whether an individual requires nursing facility care and/or specialized services. This suggests that some SMHAs may be improperly delegating this function.

c. How Do States Define and Communicate PASRR-Related Policies?

State Definition of Specialized Services. Federal regulations allow States flexibility in defining what constitutes specialized mental health services. The majority (75 percent) of States have elected to define specialized services in the most restrictive sense—as 24-hour intensive care for acute mental health needs delivered outside the nursing facility, such as in an inpatient facility. Only 13 States define specialized services more broadly; for example, as comprehensive mental health and rehabilitation services designed to increase individual functioning.

State Use of Advance Determination Categories. The majority (38) of States allow advance determinations by category. This means that States are not required to conduct PASRR screens on certain groups of people who are presumed either to meet level of care requirements for nursing facility care or to not require specialized mental health services. The most frequently cited advance determination category is dementia, followed by convalescent care (35), emergency/protective services (26), respite care (18), severe illness (15), terminal illness (15), and delirium (11).

State PASRR Training Efforts. States are responsible for communicating PASRR policy and regulations to nursing facilities so that they can comply with their responsibilities. Exhibit 8 shows the range of State training activities that respondents described. Many States employ multiple training methods that are sponsored by a variety of PASRR associated agencies (e.g., Medicaid, SMHA, aging/health authority). Most States (30) reported conducting PASRR trainings for nursing facilities on a regular basis, but 6 States indicated that they do not provide any training or outreach.

Exhibit 8: State PASRR Training for Change in Condition Procedures (n=51)

State PASRR Training	(n=50)
Conduct nursing facility trainings on a regular basis	30 (60%)
Conduct nursing facility trainings/phone consultation as needed	27 (54%)
PASRR instruction manual	11 (22%)
No trainings/outreach	6 (12%)

2. PASRR Level I and Level II Screening Documentation

States were asked to provide data from the most recent fiscal year available (FY 2001 or FY 2002) on the number PASRR screens completed annually.

Number of Level I and Level II PASRR Screens Conducted Annually. The average number of PASRR screens appears to have remained relatively consistent over the past decade, suggesting that States continue to comply with the requirement to administer PASRR screens. Exhibit 9 compares the average numbers of Level I and Level II screens in 1991 and 1993 (as documented in the Bazelon [1996] study) and 2002.

Number of Level II Change in Condition Assessments Conducted Annually. The OIG (2001) study found that Level II reassessments as a result of a "change in condition" rarely occurred. Of the 32 States providing data in the current study, more than two fifths (44 percent) reported fewer than 100 change in condition assessments were conducted in the previous year (FY 2001 or FY 2002). Coupled with the OIG study findings and results reported later in this report, this finding suggests that many States may not be in compliance with Federal requirements.

3. PASRR Level I and Level II Screening Procedures

Time Frame for Completing PASRR Screens. Exhibit 10 presents results on State guidelines for how long Level I and Level II screening procedures should take.

Exhibit 9: Average Number of Level I and Level II Screens Conducted Annually

	FY 1991	FY 1993	FY 2001/2002
Level I Screen	14,314	19,775	18,916
Level II Screen	1,009	923	972

Exhibit 10: Time Frame for Completing PASRR Screens (n=51)

Time Frame for Completing Screens	Level I Screens (n=47)	Level II Screens (n=47)
Immediate/less time than 24 hours	22 (47%)	—
Fewer than 7 working days	8 (17.0%)	30 (64%)
7–9 working days	4 (8%)	13 (28%)
10 or more working days	5 (11%)	3 (6%)
No specific guidelines	8 (17%)	1 (2%)

Level I Screens. While there are no Federal regulations specifying a time frame for completing Level I screens, in 22 States, Level I screens are completed in fewer than 24 hours after the individual is referred to a nursing facility. Many States require Level I screens to be submitted concurrently as part of the nursing facility application.

Level II Screens. Federal regulations specify that Level II screens must be completed within 7–9 business days of request, on average. In the current survey, the majority of States (30) complete Level II screens in less time than Federal regulations specify. Only three States acknowledged having difficulty meeting Federal requirements.

Professional Qualifications of Screeners. Exhibit 11 displays State requirements regarding professional qualifications of PASRR screeners.

Level I Screens. Federal regulations do not specify qualifications for Level I screeners, and a majority of States (36) allow a broad range of health professionals to complete them. These health professionals typically are nurses or social workers, but they may not necessarily have backgrounds in mental health.

Exhibit 11: Professional Qualifications of Level I and Level II Screeners (n=51)

Professional Qualifications	Level I Screens (n=46)	Level II Screens (n=51)
Any type of health professional	36 (78%)	1 (2%)
Any type of mental health professional	3 (7%)	45 (88%)
Require physician, psychiatrist, or doctoral-level psychologist	—	5 (10%)
No qualifications specified	7 (15%)	—

Level II Screens. Various types of mental health professionals are allowed to complete Level II screens in 45 States. Of the 45 States, 29 use specific credentialing requirements and allow only "qualified mental health professionals" (QMHPs) to complete Level II screens. QMHP designations typically included doctoral-level mental health professionals, licensed clinical social workers, and master-level practitioners with varying levels of experience postdegree. Regulations require that the Level II function of making or confirming a diagnosis of mental illness be performed by a QMHP.

Location of Screens. Exhibit 12 presents rankings of the locations where PASRR preadmission and resident review screens are conducted most frequently. For both Level I and Level II screens, the majority of States ranked inpatient hospitals as the most frequently used screening location, followed by nursing facilities and community-based programs. "Other" locations, such as the applicant's home, were the least frequently used locations for conducting both types of screens. The finding that a significant percentage of Level II evaluations and determination are completed in a nursing facility is difficult to interpret and depends on the definition of nursing facility. The Level II process must be completed before admission to a Medicaid-certified nursing facility. However, individuals residing in a nursing home, but in a distinct part of the facility that is not Medicaid-certified, could be appropriately evaluated before being transferred to a part of the institution that is Medicaid-certified.

Exhibit 12: Location of PASRR Preadmission and Resident Review Screens (n=51)

Screen	Location	Ranking			
		First	Second	Third	Fourth
Level I (n=46)	Inpatient hospitals	31 (67%)	12 (26%)	1 (2%)	2 (4%)
	Nursing facilities	11 (24%)	22 (48%)	7 (15%)	6 (13%)
	Community-based programs	2 (4%)	6 (13%)	20 (44%)	18 (39%)
	Other; please describe	5 (11%)	2 (4%)	5 (11%)	34 (74%)
Level II (n=47)	Inpatient hospitals	37 (79%)	5 (11%)	2 (4%)	3 (6%)
	Nursing facilities	7 (15%)	21 (45%)	14 (30%)	5 (11%)
	Community-based programs	2 (4%)	15 (32%)	15 (32%)	15 (32%)
	Other; please describe	4 (9%)	5 (10%)	4 (9%)	34 (72%)

Data Collection Methods. As indicated in Exhibit 13, the majority of States use multiple methods to gather data for Level I and Level II screens, although patient records and face-to-face interviews are the most frequently used methods.

Exhibit 13: Data Collection Methods for Level I and Level II Screens (n=51)

Method of Data Collection	Level I (n=47)	Level II (n=50)
Patient record	46 (98%)	50 (100%)
Face-to-face interview	38 (81%)	47 (94%)
Family/third party interviews	36 (77%)	44 (88%)
Written/ electronic data	29 (62%)	27 (56%)
Other source	5 (11%)	10 (20%)

Documentation of PASRR Data. Exhibit 14 shows the methods States use to document and store PASRR information. Many States use a combination of paper and electronic methods to document and store PASRR data.

Level I Screens. The majority of States (46) keep PASRR records in paper format. In 22 States, screens are stored in patient records; however, Level I contractors in 15 States and agencies with primary oversight responsibilities in 19 States also keep full copies. In addition, in 13 States, agencies with primary oversight responsibilities keep only partial records, such as summary statistics on the total number of Level I screens completed annually.

Level II Screens. Of the States reporting a method for PASRR documentation, all use paper records, and 18 also maintain electronic databases. In most States (30), whichever State agency maintains primary oversight of PASRR keeps full copies of Level II screens, while one third (17) of States maintain partial records, such as

Exhibit 14: Documentation and Storage of PASRR Screens (n=51)

How PASRR Information Is Documented	Level I (n=48)	Level II (n=48)
Paper	46 (96%)	48 (100%)
Electronic database	14 (29%)	18 (37.5%)
How PASRR Records Are Stored	**(n=44)**	**(n=51)**
Level I/II screens and determinations are kept in patient records in nursing facility	22 (50.0%)	17 (33%)
Level II contractor keeps full copies	15 (34%)	19 (37%)
Full copies kept by SMHA/State Medicaid agency/aging authority	19 (43%)	30 (59%)
Determination/summaries/statistics kept by SMHA/State Medicaid agency/aging authority	13 (30%)	17 (33%)

copies of Level II determination decisions or summary statistics on the total number of Level II screens completed annually.

Use of Standardized Assessment Tools. The majority of States require the use of standardized assessment tools for Level I (n=46) and Level II (n=47) screens, which promotes consistency of screening within each State.

4. PASRR Change in Condition Assessment Procedures

Annual Resident Reviews. Consistent with changes in the Federal statute, 43 States no longer require Level II resident reviews to be conducted annually. Instead, current statute requires nursing facilities to report a significant change in a resident's mental or physical condition to the SMHA (or designated entity) to trigger a Level II change in condition assessment.

Change in Condition Criteria and Procedures. When the requirement for annual resident reviews was eliminated in 1996, States were required to develop criteria and procedures for identifying when nursing facility residents experience a significant change in condition so that nursing facilities can initiate a Level II resident review. As shown in Exhibit 15, while 15 States use the MDS as a change in condition trigger, most States (26) developed State-specific behavioral/functional criteria, such as when a resident receives a new mental health diagnosis or if a behavior change persists after a mental health intervention. Eight States reported using Level I screening criteria to indicate a change in condition, which are not appropriate for this task. More than 40 percent of the States reported that State policy instructs nursing facilities to contact the entity designated to conduct Level II screens. This entity then is required to notify the SMHA (or designated entity). One quarter of the States require the nursing facilities to notify the SMHA directly, and one quarter require the facilities to notify another State agency that subsequently contacts the SMHA. Three States are not complying with the change in condition notification requirements.

Exhibit 15: Change in Condition Criteria and Procedures (n=51)

Change in Condition Criteria	(n=49)
Use behavioral/functional criteria developed by State	26 (53%)
Use Minimum Data Set	15 (31%)
Use Level I screen criteria	8 (16%)
SMHA Notification Process for Change in Condition	**(n=50)**
Nursing facility notifies Level II contractor directly; contractor notifies SMHA	21 (42%)
Nursing facility notifies SMHA directly	13 (26%)
Nursing facility notifies other State agency, then agency notifies SMHA	13 (26%)
Not notified systematically	3 (6%)

5. PASRR Oversight Mechanisms

State-Level PASRR Oversight Responsibilities. From interview responses, State agencies that were most directly responsible for ensuring accurate completion of Level I and Level II screens were identified and designated as having "primary" oversight responsibility. As displayed in Exhibit 16, in most States (n=31), primary Level I oversight is the responsibility of Medicaid, and Level II oversight rests with SMHAs (n=44). In 13 States, the aging or health authorities assume responsibility for primary oversight of Level I screens.

Use of PASRR Data To Monitor State Policy Goals. Exhibit 17 summarizes how States use information generated by the PASRR program. The majority use PASRR data to monitor various Level II PASRR outcomes. These include whether or not someone has a serious mental illness and if so, whether he/she currently requires specialized mental health services. Level II outcomes also determine whether or not an individual needs nursing facility level of care.

Direct Oversight of PASRR in Nursing Facilities. As presented in Exhibit 18, when asked which State agency has primary responsibility for directly overseeing the PASRR process in nursing facilities, very few respondents mentioned agencies involved in administering PASRR, such as Medicaid agencies (22 percent), SMHAs (8 percent), or aging authorities (14 percent). Instead, 75 percent of respondents indicated that the entity responsible for conducting nursing facility survey and certification is responsible for including PASRR as part of its overall quality review process. These findings are consistent with those of the 2001 OIG

Exhibit 16: Primary PASRR Oversight Responsibilities (n=51)

PASRR Activity	Medicaid	SMHA	Aging/Health Authority
Level I Screens	31 (61%)	7 (14%)	13 (25%)
Level II Screens	3 (6%)	44 (86%)	4 (8%)

Exhibit 17: How States Use PASRR Data (n=51)

Purposes of PASRR Data	Yes
Monitor PASRR outcomes	46 (90%)
SMI diagnosis	33 (65%)
– Need for nursing facility care	42 (82%)
– Need for specialized services	41 (80%)
Monitor need for alternative placements	27 (53%)
Monitor nursing facility quality of care	12 (24%)

Exhibit 18: Primary Responsibility for Direct Oversight of PASRR in Nursing Facilities (n=51)

Direct Oversight of PASRR in Nursing Facilities	(n=49)
Handled by entity that does survey/licensing of nursing facilities	37 (76%)
Handled by Medicaid agencies	11 (22%)
Handled by aging/elderly authorities	7 (14%)
Handled by SMHA	4 (8%)

Exhibit 19: State-Level Monitoring Systems (n=51)

Description of Monitoring System	Level I Screen (n=46)	Level II Screen (n=48)
Review each individual screen	19 (41%)	23 (48%)
Sample percentage of individual screens	5 (11%)	7 (15%)
Review aggregated screens	14 (30%)	19 (40%)
Monitor PASRR outcomes as part of quality improvement	9 (20%)	7 (15%)
No monitoring system in place	4 (9%)	5 (10%)
Other: e.g., regular interagency meetings	2 (4%)	1 (2%)

report. In four out of five OIG case study States, Medicaid agencies and SMHAs reported relying on State surveyors to monitor the PASRR process. None of the surveyors interviewed in these States, however, considered monitoring PASRR screens to be his/her responsibility.

State-Level Monitoring Systems. Also consistent with the OIG study findings, very few respondents described comprehensive State-level monitoring systems. As displayed in Exhibit 19, only nine States routinely monitor Level I outcomes (e.g., referred for Level II screen, meets criteria for dementia or some other categorical determination) as part of an overall quality improvement system. Even fewer States (seven) monitor Level II outcomes (e.g., has a serious mental illness, requires specialized mental health services, appropriate for nursing facility care). In addition, fewer than half of the States review individual Level I and Level II screens for accuracy and completeness of information.

B. PASRR Impact on Policy Goals

This section presents survey results that address the impact of PASRR on intended policy goals. At the State level, input centered primarily on the overall effectiveness of PASRR and availability and receipt of mental health services in nursing facilities.

1. Overall Effectiveness of PASRR

Prior to the enactment of PASARR in 1987, only eight States reported having an assessment process in place to evaluate the mental health needs of nursing facility residents. Today, all 50 States and the District of Columbia have implemented PASRR programs intended to address three main policy goals. These goals include identifying individuals with serious mental illness, screening their appropriateness for nursing facility care, and ensuring provision of specialized and other mental health services.

Level II Preadmission Screening Outcomes. States were asked to provide annual data from the most recent fiscal year available on the outcomes of Level II preadmission screens. The most frequently reported outcomes were as follows: 45 percent of States found 90–100 percent of individuals to have a serious mental illness, 58 percent of States found 90–100 percent of individuals to be appropriate for nursing

facility level of care, and 38 percent of States found 0–9 percent of individuals to require specialized services.

These very low rates of false positives from the Level I screen call into question whether the broad and rudimentary Level I screen is functioning as intended to identify all individuals who may have mental illness. It appears that in some States, the Level I screen only passes on to Level II those individuals who obviously require treatment planning for their mental illness. This practice is economical for States but is out of compliance with regulation, eliminating from evaluation those persons whose mental illness can only be determined by more sophisticated evaluation.

These findings are consistent with other studies, which report that average diversion rates (those found to be inappropriate for nursing facility care) tend to be less than 10 percent (SSWLHC, 1995; Bazelon, 1996). The results are consistent with the Bazelon findings that an average of 7–8 percent of nursing facility applicants need specialized services.

Perceived Effectiveness of PASRR Programs. Exhibit 21 compares Medicaid and SMHA ratings of the effectiveness of PASRR in achieving intended policy outcomes. Agreement between Medicaid and SMHA respondents was strong, with the majority rating PASRR as doing a "good" job of identifying individuals with serious mental illness, screening their appropriateness for nursing facility care, and ensuring provision of specialized services. Nearly half of the Medicaid and SMHA respondents reported that PASRR positively affected the type or amount of mental health services provided in their State. Both Medicaid and SMHA respondents were also

Exhibit 20: Level II Preadmission Screening Outcomes

Descriptive Statistics	Percentage Diagnosed With Serious Mental Illness (n=38)	Percentage Found Appropriate for Nursing Facility (n=40)	Percentage Found To Need Specialized Mental Health Services (n=39)
Mean	71.9%	82.9%	11.6%
Median	71.0%	94.0%	2.8%
Frequencies			
0–9%	2 (5%)	2 (5%)	15 (38%)
10–19%	0 (0%)	0 (0%)	9 (23%)
20–29%	0 (0%)	0 (0%)	6 (15%)
30–59%	8 (21%)	3 (7%)	4 (10%)
60–89%	11 (29%)	12 (30%)	0 (0%)
90–100%	17 (45%)	23 (58%)	5 (13%)

Exhibit 21: Perceived Effectiveness of PASRR Programs (n=51)

State Medicaid Respondents	Poor	Fair	Good	Excellent
Identifying individuals with serious mental illness (n=51)	1 (2.0%)	11 (22%)	22 (43%)	17 (33%)
Screening appropriateness for nursing facility care (n=49)	3 (6%)	6 (12%)	29 (59%)	11 (22%)
Ensuring provision of specialized services (n=42)	9 (21%)	12 (29%)	15 (36%)	6 (14%)
SMHA Respondents	**Poor**	**Fair**	**Good**	**Excellent**
Identifying individuals with serious mental illness (n=50)	1 (2%)	5 (10%)	24 (48%)	20 (40%)
Screening appropriateness for nursing facility care (n=47)	2 (4%)	3 (6%)	27 (57%)	15 (32%)
Ensuring provision of specialized services (n=47)	2 (4%)	3 (6%)	27 (57%)	15 (32%)

likely to indicate that PASRR positively affected the quality of mental health services in their State.

2. Availability and Receipt of Mental Health Services

Provision of Specialized Services. As described earlier, 75 percent of States define specialized services as 24-hour acute care provided in inpatient facilities. By this definition, nursing facility applicants who require specialized services to treat their mental illness would not be admitted to a nursing facility. Of the 13 States that define specialized services more broadly, definitions varied but included such services as psychosocial rehabilitation, case consultation, medication management, and crisis intervention. Most noted that while these specialized services were often provided by community mental health centers, rehabilitation agencies, nursing facilities, and individual practitioners are also eligible to provide them.

State respondents described a variety of funding sources. Use of the Medicaid rehabilitation option and State general funds were mentioned most frequently. Some States indicated that specialized services were included in the per diem rate paid to nursing facilities and mental health providers. This statement is difficult to interpret since specialized services by regulatory definition are services over and above those provided in the nursing facility benefit. States may contract with nursing facilities to provide specialized services, but such services would be reimbursed over and above the nursing facility per diem payment.

Provision of Mental Health Services of a Lesser Intensity by Nursing Facilities. Federal statute requires nursing facilities to provide mental health services (of a lesser intensity than specialized services) to

residents with mental illness; that is, services provided as part of the standard Medicaid nursing facility per diem payment, without additional reimbursement. Thirty-nine of 42 responding States indicated that Medicaid includes certain mental health services provided in the nursing facility benefit but does not cover others.

Provision of Other Mental Health Services. In addition to mental health services provided by nursing facilities and specialized services (in 13 States), other mental health services may be available from the Medicaid State plan or other sources. Most States reported that Medicaid covers psychiatric consultation (for example, medication monitoring, individual therapy, assessments) in their State plans, while fewer than half of State Medicaid plans cover rehabilitation services (for example, intensive case management, psychosocial rehabilitation).

Exhibit 22 presents further detail on the availability of mental health services and the type of practitioner providing the service. The majority of States (69 percent) reported that these services are most often provided by private independent practitioners.

Quality of Access to Mental Health Services in Nursing Facilities. Thirty-seven of the respondents completing either the State Medicaid or SMHA interview provided their perspectives on the quality of access to mental health services in nursing facilities throughout their State. Many respondents characterized access to mental health care as either being insufficient (30–32 percent) or varying considerably from facility to facility (22–30 percent) (see Exhibit 23). For example, one SMHA respondent highlighted Medicaid reimbursement as a barrier to receiving mental health services in nursing facilities, stating "Our Medicaid agency has very strict rules. If the person is in a nursing facility, Medicaid won't pay for any additional services outside of the per diem. So community mental health centers don't get paid for any services they provide for nursing facility residents."

Others highlighted the problem of variability in mental health service access that exists across nursing facilities, particularly by geographic region. Despite these largely negative characterizations, many respondents characterized overall

Exhibit 22: Mental Health Services in Nursing Facilities (n=51)

Medicaid-Covered Services	**(n=42)**
Psychiatric consultation services	38 (91%)
Rehabilitation option services	18 (42.9%)
Who Provides Mental Health Services in Nursing Facilities?	**(n=35)**
Private independent practitioners	24 (69%)
CMHC staff	14 (40%)
Contract with private behavioral health agency to provide mental health services	3 (9%)

Exhibit 23: Access to Mental Health Services in Nursing Facilities (n=51)

Quality of Access of Mental Health Services in Nursing Facilities	**State Medicaid (n=37)**	**SMHA (n=37)**
Good access to mental health services	18 (49%)	18 (49%)
Not enough mental health services are being provided in nursing facilities	11 (30%)	12 (32%)
Varies from facility to facility	11 (30%)	8 (22%)

access as good. A typical Medicaid agency response was, "I don't think we have a problem. . . . Medicaid does get a significant number of claims for mental health services for nursing facility residents, so I think it is working okay."

C. PASRR Issues Identified at the State Level

The following section describes issues that State respondents identified as important to the PASRR process, including how PASRR relates to broader State system issues, such as Olmstead and the availability of community-based alternatives to institutional care. Also reported are additional State respondent perceptions about PASRR and recommendations to CMS, State PASRR agencies, and nursing facilities for improving the PASRR process.

1. How PASRR Relates to Broader System Issues

Relationship Between PASRR and Olmstead Planning. In response to the 1999 Olmstead decision, many States are reexamining their decisionmaking process for institutional and community-based placements for disabled populations, including people with psychiatric disabilities.

Exhibit 24: PASRR and Olmstead (n=51)

Consideration of PASRR as Part of Olmstead Planning	(n=50)
Active consideration of PASRR as part of Olmstead planning	14 (28%)
Some consideration of PASRR as part of Olmstead planning	20 (40%)
No consideration of PASRR as part of Olmstead planning	16 (32%)

As illustrated in Exhibit 24, the majority of States (34) indicated active consideration or some consideration of PASRR within the broader context of their Olmstead planning.

Use of Home and Community-Based Services (HCBS) Waivers. In 38 States, HCBS waivers cannot be used to move individuals with serious mental illness from institutional settings, such as psychiatric hospitals and nursing facilities, into community placements. Many respondents explained that the HCBS waiver statute requires States to demonstrate the cost-effectiveness of care provided in community-based programs relative to care provided in institutional settings. However, because Medicaid does not pay for care of individuals residing in institutes for mental disease (IMDs), many States reported that they are unable to generate the appropriate cost comparisons needed to demonstrate cost neutrality, a requirement of HCBS waivers. For example, one State Medicaid agency representative explained, "Because you have to prove cost effectiveness and Medicaid doesn't pay for IMDs, it is hard to make the comparison to determine cost-effectiveness." Similarly, a mental health authority respondent from another State said, "It's hard for us to make the waiver math work!"

Effect of PASRR on Acute Care Discharges. Some stakeholder organizations have raised concerns about PASRR's effect on State acute care systems. A 1995 survey by the Society of Social Work Leadership in Health Care described concerns on the part of hospitals and nursing facilities that the complexities of the PASRR screening process can create costly delays in discharges. In this study, when asked directly about PASRR's impact on acute care discharges, almost three quarters of the States responding highlighted negative effects, such as delays in

discharge and additional costs incurred. However, more than a third noted PASRR's positive effects, such as preventing inappropriate discharges and making hospital staff more aware of individual mental health needs.

Alternatives to Nursing Facility Placement. When individuals are determined through the PASRR screening process to not require nursing facility level care, States must arrange for some type of alternative placement. Exhibit 25 presents information on what kinds of alternative placements and funding sources are available in the States. The majority of State respondents (39) indicated that their State provides some type of community-based mental health residential or intensive support programs (e.g., group homes, board/care, supported apartments, assertive community treatment). Less than a third specifically mentioned inpatient psychiatric facilities as an alternative to nursing facility placement. Regarding funding mechanisms, most respondents reported that their States use a combination of funding streams, such as State funds, Medicaid, and other sources (e.g., Medicare, private insurance, county grants).

Exhibit 25: Alternative Placements (n=51)

Alternative Placements	(n=47)
Community-based mental health residential programs	39 (83%)
State psychiatric facility or other IMD	15 (32%)
Assisted living facility or other senior residential programs	17 (36%)
Funding Mechanisms for Alternative Placements	**(n=45)**
State funds	28 (62%)
Medicaid	34 (76%)
Other payers	21 (47%)

2. State Respondent Perceptions of PASRR

Strengths of PASRR Screening Process. As presented in Exhibit 26, when asked to describe the strengths of the PASRR program, both SMHA and Medicaid agency respondents most often reported a specific policy goal, such as preventing the inappropriate admission of people with serious mental illness to nursing facilities, ensuring that people with serious mental illness are identified, and ensuring access to specialized services. One Medicaid agency respondent stated, "PASRR has forced people to be concerned about the seriously mentally ill population . . . the program has helped ensure no dumping in institutions." Nearly one third of Medicaid agency and 14 percent of SMHA respondents also described PASRR as helping to increase nursing facility resident access to nonspecialized mental health services. One SMHA respondent indicated, "PASRR has improved the quality of care [in nursing facilities] by educating staff about different diagnoses."

Weaknesses of PASRR Screening Process. Exhibit 27 reports findings regarding perceived PASRR program weaknesses. State agencies most commonly highlighted oversight issues, such as how there is comparatively little energy or resources devoted to follow-up and that States often lack a "stick" (punitive disincentive) to enforce nursing facility compliance with PASRR. As one SMHA respondent noted, "Enforcement of PASRR is nonexistent in terms of people getting services they need or being placed in alternative settings. It can

Exhibit 26: PASRR Strengths (n=51)

Strengths of the PASRR Screening Process	State Medicaid (n=40)	SMHA (n=51)
Prevents inappropriate admission of people with serious mental illness to nursing facilities	23 (58%)	18 (35%)
Ensures that people with serious mental illness are identified	16 (40%)	16 (31%)
Ensures that people get specialized services	10 (25%)	15 (29%)
Increases access to nonspecialized mental health services	12 (30%)	7 (14%)

Exhibit 27: PASRR Weaknesses (n=51)

Weaknesses of the PASRR Screening Process	State Medicaid (n=35)	SMHA (n=38)
No "stick" for enforcing compliance with any part of PASRR	21 (60%)	20 (53%)
Federal regulations unclear, complicated	12 (34%)	18 (47%)
Delays admissions, even when necessary	7 (20%)	8 (21%)
Does not appropriately deal with Alzheimer's/dementia patients	4 (11%)	1 (3%)

turn into a paper shuffle and nothing ever happens."

Many also expressed frustration with the lack of clarity surrounding many of the Federal regulations. As articulated by one Medicaid respondent, "PASRR rules and regulations are complicated, and it takes a lot of effort to get the details down—especially for people who don't deal with it every day." A small number of Medicaid respondents also noted that PASRR does not appropriately address the needs of people with Alzheimer's or dementia. For example, one respondent explained, "PASRR doesn't properly recognize dementia and Alzheimer's. They get admitted to nursing facilities with all sorts of problems. It's a gray area—I can see why they are excluded [from PASRR], but there needs to be a better way to get them recognized and treated."

3. Recommendations for Improving PASRR

- **Increase guidance to States, clarify/modify certain regulations.** The top suggestion among State agency respondents was to request that CMS provide additional guidance on the PASRR process. This recommendation was often framed as needing more clarification regarding PASRR's overall intent. For example, one Medicaid respondent explained, "CMS needs more resources to support State efforts to implement PASRR. Their intent was good, but what's the point if they aren't following it up. It shouldn't be me

Exhibit 28: Recommendations to CMS for the PASRR Process (n=51)

Recommendations for CMS	State Medicaid (n=41)	SMHA (n=42)
Increase guidance to States, clarify/modify regulations	22 (54%)	22 (52%)
Strengthen oversight activities	8 (20%)	12 (29%)
Establish Federal definition of specialized services	4 (10%)	9 (21%)
Address funding issues with Medicaid program and PASRR	5 (12%)	6 (14%)

determining how it's implemented without clarification from CMS." In fact, many respondents specifically called for CMS to establish a Federal definition of specialized services that accurately reflects the intent of the original legislation.

- **Strengthen oversight.** Along with the request for increased CMS guidance, almost one quarter of the States called for increased oversight from CMS to help guide and shape State PASRR programs. For example, one Medicaid respondent indicated, "We don't have much to do with CMS. They should get to know how these processes work [in our State] and get more involved." Many respondents articulated a desire for CMS to mandate and provide support for monitoring systems so that their agency could strengthen oversight of nursing facilities and discharge entities. A typical comment included, "I wish that CMS were more active in giving States 'some teeth' to make folks comply. Maybe legislate it. There is a long history in this State of noncompliance."
- **Establish Federal definition of specialized services."** Although PASRR regulations mandate that States arrange for the provision of specialized mental health services, CMS allows each State to create its own requirements for the kinds of services that qualify as "specialized." This latitude allows States' variations and flexibility, but may create some confusion from one State to another.
- **Address funding issues with Medicaid/PASRR**. States also appear to have many specific financing questions (e.g., what Medicaid does and does not cover) and are also concerned about what they perceive as a lack of financial incentives for nursing facilities to provide mental health services. This particular sentiment was echoed by an SMHA respondent: "Payment for psychiatric services in nursing facilities is so low, they really have to kick in some of their own money for payments to psychiatrists. I think they do a pretty good job considering this resource limitation." A Medicaid respondent added that CMS needs to "expand what Medicaid/Medicare can bill for mental health services and broaden the resources available."

Recommendations for State Agencies. As shown in Exhibit 29, respondents also were asked to provide suggestions for how their own agencies might improve PASRR effectiveness.

Exhibit 29: Recommendations to State Agencies for the PASRR Process (n=51)

Recommendations to State Agencies	State Medicaid (n=37)	SMHA (n=36)
Strengthen oversight	11 (30%)	13 (36%)
Increase coordination with other PASRR agencies	5 (14%)	9 (25%)
Make PASRR and PASRR population more of a priority	5 (14%)	7 (19%)
Educate nursing facilities and discharge agencies on PASRR	7 (19%)	3 (8%)
Increase monetary resources that are available	4 (11%)	6 (17%)
Improve Medicaid billing process, rules, and/or technology	2 (5%)	2 (6%)

- **Strengthen oversight.** Similar to recommendations for CMS, many respondents underscored the relative weakness of existing State oversight mechanisms and the corresponding need to improve this process to meet the goal of "ensuring" that nursing facility residents have access to appropriate mental health services. One Medicaid respondent went so far as to suggest that Medicaid "reinstitute the annual resident review. . . . [This] would make [oversight] a tighter process. . . . We need to ensure that quality of care is improved in nursing facilities and the Department of Public Health going in once a year is not enough."
- **Increase efforts to coordinate and communicate with other PASRR agencies.** Data from the national survey show that States often involve multiple agencies in administering PASRR, which necessitates regular communication and coordination to ensure successful program administration. Nearly a quarter of the respondents—Medicaid, SMHA, or a third agency—made this recommendation to their own agency. For example, one Medicaid respondent highlighted the complexity of her State's system: "There are at least four departments that are responsible for PASRR—Medicaid, Elder Affairs, Health, and the Department of Mental Health. Just by having so many State agencies involved, not to mention the local level, it is inherent that there will be snags."
- **Make PASRR and PASRR populations more of a priority.** Several respondents urged their agency to make PASRR and PASRR target populations a greater priority. For Medicaid and aging and health authorities, this often meant expanding agency focus to include individuals with serious mental illness, while for SMHAs, the needs of aging/geriatric populations were perceived as taking a backseat to populations of individuals with serious mental illness. An SMHA respondent focused on the need to educate health care professionals, remarking that "within the State, we need to have more training on how to do PASRR, as well as more education about the elderly and mental illness for general health practitioners. Care is often fragmented

for people with serious mental illness, and now that we are trying to address aging needs, there needs to be a lot of education for people in general health care about how to identify people with mental health needs."

- **Educate nursing facilities and discharge agencies on PASRR.** A gap highlighted by the national survey is the number of States that do not provide regular or even "as needed" PASRR training to nursing facilities. Recognizing this problem, several survey respondents also recommended expanding their training and outreach to nursing facilities. Nursing facility staff turnover issues were underscored as an issue by one Medicaid respondent: "Nursing facility staff turn over so quickly that we need to figure out how to do continuing education—other than the four yearly trainings—and give them the same message every time."
- **Increase monetary resources that are available.**
- **Improve Medicaid billing process, rules, and/or technology.**

Recommendations for Nursing Facilities. As presented in Exhibit 30, State respondents also provided suggestions for how nursing facilities might improve their PASRR responsiveness. Key recommendations appear below.

- **Increase training in PASRR for nursing facility staff.** Respondents recommended that nursing facilities should devote more training to PASRR. In a joint interview, Medicaid and mental health agency staff in one State summarized the issue as follows: "Training new staff is key . . . turnover is a big problem. Nursing facilities have a great burden to fully understand the needs of new residents and staff doesn't always understand that."
- **Increase training in mental health issues for nursing facility staff.** Respondents recommended that nursing facility staff receive more training in mental health issues generally.
- **Make PASRR more of a priority.** Respondents also framed training issues in terms of nursing facilities needing to make PASRR and residents with mental illness more of a priority by recognizing how information collected through the PASRR process might be incorporated into overall treatment planning, rather than viewed as a burdensome paperwork requirement.

Exhibit 30: Recommendations to Nursing Facilities for the PASRR Process (n=51)

Recommendations to Nursing Facilities	State Medicaid (n=30)	SMHA (n=31)
Increase training in PASRR for nursing facility staff	18 (60%)	11 (35%)
Increase training in mental health issues for nursing facility staff	7 (23%)	6 (19%)
Make PASRR more of a priority	8 (27%)	3 (10%)
Provide additional mental health services in nursing facilities	2 (7%)	5 (16%)

- **Provide additional mental health services in nursing facilities.** Among some State-level respondents, there was a perception that many nursing facilities could do more to improve resident access to mental health services—either by increasing the number of providers available or offering a wider array of service options. While advocating this point, one SMHA respondent was also sensitive to nursing facility resource constraints: "Nursing facilities need to provide more mental health services within their own resources; however, this is a difficult demand to place on nursing facilities, particularly given the increasing geriatric population and the diversity of needs."

Barriers to Changing PASRR Process. Respondents were asked about perceived barriers to making the recommended changes above. As Exhibit 31 shows, the majority of respondents indicated that barriers existed, the most common of which was an overall lack of State resources—financial, infrastructure, and personnel—to dedicate toward strengthening the PASRR process. One Medicaid respondent highlighted financial difficulties: "Money is the biggest one . . . but time will force them to rethink things, because more and more people will need services." Others noted the lack of political will and State agency resistance to change. As one SMHA respondent succinctly stated, "PASRR is a low priority for everyone, so this is a barrier—nobody is paying attention." A Medicaid respondent highlighted resistance issues: "We have gotten used to using PASRR in a certain way, so it is hard to change. It's a burden when you've got your system in place and then the Federal rules change."

Exhibit 31: Barriers to Changes in the PASRR Process (n=51)

Barriers to Changes in the PASRR Process	State Medicaid (n=43)	SMHA (n=46)
Yes	35 (81%)	33 (72%)
No	8 (19%)	13 (28%)
If yes, please describe	**(n=35)**	**(n=32)**
Lack of resources (financial and nonfinancial)	21 (48%)	23 (52%)
Lack of political will; resistance to change	12 (27%)	7 (16%)
Federal government must initiate change	9 (26%)	5 (16%)
Lack of coordination across agencies	3 (9%)	3 (9%)

VI. In-Depth State Study Findings

In-depth case studies were conducted in four States to gain a better understanding of the experiences of nursing facility administrators, staff, and residents regarding how the PASRR process works at local levels. Results of these in-depth studies are limited and not generalizable to the State or national levels. Instead, they are considered exploratory in nature and intended to identify topics where SAMHSA and CMS can provide further guidance to SMHAs, Medicaid agencies, and nursing facilities.

Section A describes State, nursing facility, medical record, and clinical interview samples. Sections B–D synthesize findings across these different data sources to address the following core research questions:

1. How are nursing facilities implementing PASRR? (Section B)
2. How has PASRR affected its intended policy goals? (Section C)
3. What issues have nursing facilities identified throughout PASRR implementation? (Section D)

A. In-Depth Study Samples

1. State Sample

Exhibit 32 presents national survey results on key organizational and structural characteristics of the States selected for in-depth study.

State Agencies Involved in PASRR/Primary Oversight Responsibilities. States 1 and 2 fit the typical profile of having two State agencies involved in PASRR: Medicaid (for Level I) and the SMHA (for Level II). State 3 is one of only four States that have three State agencies involved in PASRR—the State Medicaid, mental health, and aging authorities. In State 4, the State aging authority plays a primary role in Level I administration, while the SMHA is responsible for Level II PASRR functions. It appears that in this State, the Medicaid agency does not perform its required functions.

State Agency Centralization Versus Decentralization. As discussed in Section V of this report, the degree of centralization between Medicaid, the SMHA, and other related agencies is different across the States and may influence the level of coordination among these agencies in administering PASRR programs. Within the four selected States, PASRR agencies in three States are distinct entities that are physically separated from one another. Only in State 4 are PASRR agencies subsumed under a single umbrella agency.

Entity Designated To Conduct PASRR Screens. Level I screens are conducted by nursing facilities and/or referral sources in three out of four States. As a primary

Exhibit 32: Organizational and Structural Characteristics of In-Depth Study States (n=4)

	State 1	State 2	State 3	State 4
State Agencies Involved in PASRR				
	Medicaid, SMHA	Medicaid, SMHA	Medicaid, SMHA, aging authorities	SMHA, aging authorities
Primary Oversight Responsibilities				
Level I	Medicaid	Medicaid	Medicaid	Aging authorities
Level II	SMHA	SMHA	SMHA	SMHA
Degree of Centralization				
	Two separate agencies	Two separate agencies	Three separate agencies	Two agencies under umbrella agency
Entity Designated To Conduct PASRR Screens				
Level I	Nursing facility or referral source	Nursing facility or referral source	Nursing facility or referral source	Aging authorities
Level II	Individual practitioners, aging authorities	Private vendor	Community mental health clinics, local mental health authorities	Individual practitioners

stratification variable in selecting in-depth study States, however, each of the four States designates a different entity as responsible for conducting Level II screens, including the aging authority, private behavioral health vendors, local public mental health authorities, and individual practitioners.

Number of PASRR Screens Completed Annually. Findings on the number of Level I and Level II screens conducted annually for the four in-depth study States are in keeping with national survey results (see Exhibit 33). States 1 and 4 completed fewer than 10,000 Level I screens annually, while State 3

Exhibit 33: Annual PASRR Screens Completed by In-Depth Study States (n=4)

Number of PASRR Screens Completed Annually	State 1	State 2	State 3	State 4
Level I Screens	3,725	n/a	70,248	1,870
Level II Screens				
– Preadmission	202	450	2,330	500
– Change in condition	447	56	555	124

conducted well over 20,000 Level I screens in the sample year. Annual Level II screens (both preadmission and change in condition) were also high for State 3, while figures for States 1, 2, and 4 were consistent with national survey results.

2. Nursing Facility Sample

a. Nursing Facility Characteristics

As presented in Exhibit 34, a total of 24 facilities were selected from the four States (six per State). To capture urban and rural variation within each State, three facilities from a rural county and three from an urban county were selected. In addition, in each area (urban or rural), nursing facilities were stratified according to size (small, medium, and large), based on the number of available beds. Average small facilities ranged from 35 to 49 beds, medium-sized facilities from 60 to 78 beds, and large facilities from 104 to 168 beds. In States 1, 2, and 3, a majority of facilities sampled were for-profit, under the auspices of a corporation or a partnership. In State 4, however, most nursing facilities held nonprofit status as a corporation or faith-based entity. Of the 24 facilities sampled, 17 operated autonomously, while 7 belonged to a multi-nursing-home ownership. Additionally, only one of the facilities sampled was located within a hospital.

b. Nursing Facility Quality Performance

Participating nursing facilities submitted summary statistics on MDS quality indicators. Because these indicators are framed as negative events, higher facility percentages and percentiles are seen to indicate poorer performance. MDS aggregates 24 individual indicators into the following 11 categories: accidents, behavior/emotional patterns, clinical management, cognitive patterns, elimination/incontinence, infection control, nutrition/eating, physical functioning, psychotropic drug use, quality of life, and skin care.

Exhibit 1 in Appendix A provides average facility-specific percentages and percentile rankings for each State. All facilities appear to be in the normal/average range across the full range of quality indicators. Regarding specific quality indicators relating to mental health, all States were in the average range for resident behavior and emotional patterns (none above 57th percentile). Similarly, among the sampled facilities, on average, 8 percent of the residents were cognitively impaired, placing no State above the 62nd percentile. Indicators relating to the use of psychotropic drugs measured the prevalence of antipsychotic, antianxiety, and hypnotic use. Across all four States, scores ranged from the 42nd to the 65th percentile.

c. Nursing Facility Residents' Diagnoses

Across all States, of the nursing facility resident records reviewed, primary diagnoses (e.g., first diagnosis listed in medical record) for the majority of residents indicated a physical (versus mental) health condition. This was true at initial admission and currently. Within States 1 and 2, there were roughly equivalent percentages of individuals with primary diagnoses of dementia/Alzheimer's or mental illness, comparing initial admission to "currently." In States 3 and 4, however, there were higher numbers of Alzheimer's/dementia diagnoses at initial admission and currently (see Exhibit 35).

Exhibit 34: Characteristics of Nursing Facility Sample (n=24)

	State 1 (n=6)	State 2 (n=6)	State 3 (n=6)	State 4 (n=6)
Nursing Facility Location				
Urban	3	3	3	3
Rural	3	3	3	3
Nursing Facility Size				
Small	49	36	39	35
Medium	61	60	78	82
Large	156	130	104	168
Profit Status				
For profit—corporation	3	2	4	2
For profit—partnership	1	2	0	0
Nonprofit—corporation	1	1	1	3
Nonprofit—faith-based	1	1	1	1
Multi-Nursing-Home Ownership				
Yes	1	1	4	1
No	5	5	2	5
Located Within a Hospital				
No	6	6	6	5

Exhibit 35: Primary Diagnoses of Nursing Facility Resident Record Review Sample (n=786)

Primary Diagnosis	State 1 (n=215)	State 2 (n=213)	State 3 (n=177)	State 4 (n=181)
Upon Admission	**(n=215)**	**(n=212)**	**(n=177)**	**(n=181)**
Physical	150 (70%)	182 (86%)	112 (63%)	117 (65%)
Mental	25 (12%)	11 (5%)	19 (11%)	21 (12%)
Substance abuse	2 (1%)	0 (0%)	0 (0%)	2 (1%)
Alzheimer's, dementia	38 (18%)	20 (9%)	46 (26%)	41 (23%)
Currently	**(n=215)**	**(n=213)**	**(n=177)**	**(n=181)**
Physical	151 (70%)	176 (83%)	97 (55%)	106 (59%)
Mental	24 (11%)	19 (9%)	23 (13%)	23 (13%)
Substance abuse	0 (0%)	0 (0%)	0 (0%)	2 (1%)
Alzheimer's, dementia	40 (19%)	18 (8%)	57 (32%)	50 (28%)

Physical Health Diagnoses. Nearly all records reviewed indicated a physical health diagnosis, ranging from 93–98 percent upon admission to 97–99 percent currently. Across all four States, disorders of the nervous system (e.g., dementia/Alzheimer's, dysphagia) were the most frequently diagnosed conditions both at time of initial admission and currently. This was followed by disorders of the circulatory system (e.g., atrial fibrillation, hypertension). Other commonly diagnosed medical disorders included: musculoskeletal/connective tissue (e.g., arthritis, osteoporosis); endocrine/nutritional/metabolic (e.g., diabetes, hypothyroidism); and digestive (e.g., hernia, peptic ulcer disease). In all four States, there were typically increases in diagnosis of physical health conditions over time from initial admission to the current record review (see Exhibit 36).

Exhibit 36: Physical Health Conditions of Nursing Facility Resident Sample (n=786)

	State 1		State 2		State 3		State 4	
	Initial (n=215)	Current (n=215)	Initial (n=212)	Current (n=213)	Initial (n=177)	Current (n=177)	Initial (n=181)	Current (n=181)
Major Disease Categories* for Physical Health Conditions	**206 (96%)**	**209 (97%)**	**206 (97%)**	**207 (97%)**	**165 (93%)**	**176 (99%)**	**178 (98%)**	**180 (99%)**
Nervous system	140 (65%)	160 (74%)	157 (74%)	159 (75%)	120 (68%)	148 (84%)	142 (78%)	153 (85%)
Circulatory	147 (68%)	160 (74%)	135 (64%)	151 (71%)	112 (63%)	134 (76%)	121 (67%)	133 (73%)
Musculoskeletal	82 (38%)	82 (38%)	113 (53%)	109 (51%)	79 (45%)	95 (54%)	81 (45%)	93 (51%)
Endocrine/nutritional/ metabolic	89 (41%)	106 (49%)	72 (34%)	85 (40%)	62 (35%)	79 (45%)	80 (44%)	85 (47%)
Digestive	68 (32%)	84 (39%)	57 (27%)	71 (33%)	34 (19%)	62 (35%)	59 (33%)	64 (35%)
Respiratory	56 (26%)	61 (28%)	47 (22%)	52 (25%)	43 (24%)	47 (27%)	38 (21%)	38 (21%)
Kidney/urinary tract	42 (20%)	55 (26%)	36 (17%)	38 (18%)	36 (20%)	43 (24%)	41 (23%)	38 (21%)
Blood/immunological	40 (19%)	48 (22%)	23 (11%)	35 (17%)	14 (8%)	24 (14%)	32 (18%)	37 (20%)
Skin/breast	31 (14%)	35 (16%)	23 (11%)	30 (14%)	15 (8%)	19 (11%)	29 (16%)	37 (20%)
Eye	22 (10%)	37 (17%)	17 (8%)	18 (8%)	17 (10%)	33 (19%)	12 (7%)	18 (10%)
Infections/parasitic diseases	10 (5%)	11 (5%)	9 (4%)	10 (5%)	1 (1%)	0 (0%)	5 (3%)	4 (2%)
Ear/nose/mouth/throat	3 (1%)	11 (5%)	4 (2%)	7 (3%)	5 (3%)	7 (4%)	9 (5%)	9 (5%)
Hepatobiliary/pancreas	11 (5%)	12 (6%)	6 (3%)	7 (3%)	4 (2%)	6 (3%)	10 (6%)	12 (7%)
Male reproductive	9 (4%)	11 (5%)	10 (5%)	9 (4%)	3 (2%)	6 (3%)	8 (4%)	9 (5%)
Female reproductive	7 (3%)	10 (5%)	3 (1%)	1 (0%)	3 (2%)	4 (2%)	3 (2%)	3 (2%)
Myeloproliferative/ neoplasms	6 (3%)	5 (2%)	4 (2%)	1 (0%)	0 (0%)	1 (1%)	1 (1%)	1 (1%)
Injury/poisoning/ toxic drugs	2 (1%)	3 (1%)	5 (2%)	2 (1%)	1 (1%)	0 (0%)	2 (1%)	1 (1%)
Burns	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Multiple significant trauma	2 (1%)	3 (1%)	7 (3%)	8 (4%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
HIV	2 (1%)	1 (0%)	0 (0%)	1 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

** 2001 DRG Guide (2000)*

Exhibit 37: Number of Physical Health Diagnoses per Resident for Nursing Facility Resident Record Review Sample (n=786)

Number per Resident	State 1 (n=215)	State 2 (n=213)	State 3 (n=177)	State 4 (n=181)
Upon Admission				
1–3 diagnoses	31 (14%)	57 (27%)	45 (25%)	15 (8%)
4–6 diagnoses	106 (49%)	82 (39%)	76 (43%)	59 (33%)
7–9 diagnoses	70 (33%)	58 (27%)	39 (22%)	87 (48%)
10+ diagnoses	9 (4%)	15 (7%)	17 (10%)	20 (11%)
Currently				
1–3 diagnoses	13 (6%)	48 (23%)	8 (5%)	3 (2%)
4–6 diagnoses	88 (41%)	73 (34%)	39 (22%)	35 (19%)
7–9 diagnoses	72 (33%)	67 (31%)	86 (49%)	94 (52%)
10+ diagnoses	42 (20%)	25 (12%)	44 (25%)	49 (27%)

Number of Physical Health Conditions per Resident. In States 1, 2, and 3, the average nursing facility resident in the medical record sample had between four and six medical diagnoses at the time of initial admission. This number was slightly higher (seven to nine diagnoses) for State 4. For current diagnoses, these numbers generally remained at the same levels (see Exhibit 37).

3. Medical Record Review Sample

Nursing facility residents with potential mental illness were randomly selected based on criteria described in Section IV. An average of 30–40 medical records were reviewed at each nursing facility in all four States, for a total of 786 records.

a. Background Characteristics

Exhibit 38 presents background characteristics of the nursing facility resident medical record sample. The average age for nursing facility residents whose medical records were sampled in States 1 and 2 was 80–90; for States 3 and 4, the average age was slightly younger at 65–79. Overall, there were relatively low percentages of nursing facility residents under 65 across all 4 States, with numbers ranging from 6 percent (State 2) to 20 percent (State 4). In all four States, the majority of records sampled were female, widowed, and White.

Exhibit 38: Demographics of Nursing Facility Resident Record Sample (n=786)

Demographics	State 1 (n=215)	State 2 (n=213)	State 3 (n=177)	State 4 (n=181)
Age	**(n=204)**	**(n=209)**	**(n=177)**	**(n=181)**
35–49	2 (1%)	4 (2%)	6 (3%)	14 (8%)
50–64	12 (6%)	9 (4%)	14 (8%)	21 (12%)
65–79	45 (22%)	48 (23%)	69 (39%)	56 (31%)
80–84	52 (25%)	51 (24%)	30 (17%)	42 (23%)
85–90	49 (24%)	55 (26%)	37 (21%)	25 (14%)
>90	44 (22%)	42 (20%)	21 (12%)	23 (13%)
Gender	**(n=212)**	**(n=207)**	**(n=176)**	(n=181)
Female	167 (79%)	167 (81%)	125 (71%)	124 (69%)
Male	45 (21%)	40 (19%)	51 (29%)	57 (31%)
Marital Status	**(n=214)**	**(n=208)**	**(n=177)**	(n=181)
Single/never married	27 (13%)	17 (8%)	35 (20%)	32 (18%)
Married	24 (11%)	57 (27%)	33 (19%)	26 (14%)
Divorced/separated	25 (12%)	13 (6%)	33 (19%)	34 (19%)
Widowed	138 (64%)	121 (58%)	76 (43%)	89 (49%)
Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Race/Ethnicity	**(n=210)**	**(n=204)**	**(n=177)**	(n=181)
White	203 (97%)	193 (95%)	137 (77%)	173 (96%)
African American	3 (1%)	8 (4%)	39 (22%)	2 (1%)
Asian American/Pacific Islander	0 (0%)	1 (0.5%)	1 (1%)	1 (1%)
American Indian/Alaska Native	1 (0.5%)	0 (0%)	0 (0%)	1 (1%)
Hispanic/Latino(a)	3 (1%)	1 (0.5%)	0 (0%)	4 (2%)

b. Admissions Information

Exhibit 39 presents admissions information for the sample of 786 nursing facility residents whose medical records were reviewed. Across all four States, most residents were referred to nursing facilities from hospitals or acute care settings. The next highest percentage of referrals came from other nursing facilities and assisted living facilities. Many nursing facility residents in State 3 were also referred from their private residences. State 1 had a much higher percentage of referrals from psychiatric facilities (13 percent) as compared to other States (2 percent).

Exhibit 39: Referral Source for Nursing Facility Resident Record Review Sample (n=786)

	State 1	State 2	State 3	State 4
Referral Source	**(n=210)**	**(n=208)**	**(n=161)**	**(n=180)**
Nonpsychiatric hospital	83 (40%)	118 (57%)	86 (53%)	123 (68%)
Psychiatric hospital/psychiatric ward	28 (13%)	5 (2%)	3 (2%)	4 (2%)
Nursing facility/assisted living facility	55 (26%)	51 (25%)	26 (15%)	37 (21%)
Private residence	43 (20%)	34 (16%)	43 (27%)	14 (8%)
Other	1 (0.5%)	0 (0%)	3 (2%)	2 (1%)

In all four States, nursing facilities most frequently recorded a specific physical or psychiatric diagnosis as the reason for admission. Other commonly cited admission reasons included: individual needs nursing facility level of care; individual needs assistance with activities of daily living or indirect activities of daily living; and individual has multiple, complex medical conditions (see Exhibit 2 in Appendix A).

4. Clinical Interview Sample

To conduct clinical interviews in States 1 and 2, a sample of residents was drawn from the larger medical record sample. If residents refused to participate (n=21–26) or screened positive for dementia (n=43–48), they were replaced with another record from the larger sample in order to interview an average of 7–9 residents per facility. A total of 93 clinical interviews were conducted across both States.

As illustrated in Exhibit 48 (and in Appendix A, Exhibits 3 and 4), data on background characteristics and admissions information are comparable generally between clinical interview and medical record samples. Demographically, the clinical interview sample tended to be slightly younger, although this may be attributable in part to having screened out participants with dementia, who tended to be slightly older. No other background characteristics (e.g., gender, marital status, and race/ethnicity) appeared to differ substantially across the two samples. Admissions information reveals there are slight differences between clinical interview and medical record samples in both States. In State 1, a larger percentage of the clinical interview sample was referred from nonpsychiatric hospitals and fewer from private residences. In State 2, there were fewer clinical interview participants who had been referred from nursing and assisted living facilities and more referred from private residences.

B. PASRR Implementation at the Nursing Facility Level

One primary goal of the current study was to gather information about implementation of PASRR at the nursing facility level. Throughout this section of the report, data and qualitative evidence are integrated from nursing facility staff interviews (n=24) and resident record reviews (n=786).

1. PASRR Level I and Level II documentation

a. Are Level I and Level II Screens Being Completed?

Evidence of PASRR Level I and Level II Screens in Medical Records. The extent to which PASRR Level I and Level II screens are appropriately documented in nursing facility charts is an indicator of how well referring agencies and nursing facilities are implementing PASRR programs. Exhibit 40 presents medical record review findings on Level I and Level II documentation.

Level I Screens. Across the four States, percentages of Level I screens found in medical records ranged from 71 percent in State 3 to 93 percent in State 4. While not specifically required to be documented in the patient record, PASRR regulations require 100 percent of individuals admitted to a Medicaid nursing facility to have Level I screens regardless of resident funding source. While the documentation in our sample did not reach 100 percent, it is higher than rates of documentation in the 2001 OIG report findings, which indicated that only 88 of 187 (47 percent) reviewed charts contained Level I screens in five case study States.

Level II Screens. States are required to conduct Level II screens on nursing facility applicants suspected of having a serious mental illness based on Level I screening results. In the current sample, 0–14 percent of individuals who received a Level I screen subsequently were administered a Level II screen, as evidenced in their patient record. According to Linkins et al. (2001), previous studies have found rates in the 6–7 percent ranges (Borson et al., 1997; Bazelon, 1996). States 2 and 4 appear to be in this range, while results suggest that State 1 nursing facilities in the sample administered Level II screens to a greater proportion of applicants. By contrast, in State 3, no Level II screens were found in the medical records of individuals with Level I screens. These findings cannot be compared to those in the OIG report's investigation because the current study did not purposively sample nursing facilities with high percentages of residents with mental illness.

2. PASRR Change in Condition Documentation and Procedures

When the requirement for annual resident review was eliminated in 1996, nursing facilities were given the responsibility of identifying when residents experience a significant "change in physical or mental condition" to trigger a Level II screen. This section reports on nursing facility staff interview and medical record data to assess the extent to which nursing facilities in our sample appropriately documented change in

Exhibit 40: Presence of PASRR Documentation in Medical Records (n=786)

	State 1 (n=215)	State 2 (n=213)	State 3 (n=176)	State 4 (n=181)
Level I	175 (81%)	167 (78%)	125 (71%)	168 (93%)
Individuals received Level I screen	(n=175)	(n=167)	(n=125)	(n=168)
Also received Level II screen	24 (14%)	6 (4%)	0 (0%)	14 (8%)

condition assessments in medical records and have developed specific policies and procedures in this area.

a. Are Nursing Facilities Completing Change in Condition Assessments?

Evidence of Change in Condition Assessments in Medical Records. In the medical records in all four States, very few change in condition assessments were found (10 percent in one State, 1 percent in the other three States). There is no objective standard in the literature against which to compare these numbers.

b. Are Nursing Facilities Familiar With Change in Condition Criteria and Procedures?

Change in Condition Criteria. The extent to which nursing facilities have developed policies and procedures for change in condition assessments can also contribute to our understanding of the quality of documentation in medical records. OIG (2001) found that 16 out of 19 nursing facilities sampled in five case study States were unclear as to change in condition criteria. In our sample, many nursing facility staff in States 2 and 3 appeared unfamiliar with the 1996 PASRR-related change in condition criteria (see Exhibit 41). In State 2, no respondents described specific criteria, while in State 3, the percentage of staff reporting specific "change in condition" criteria was 33 percent. Respondents from these two States typically explained that their nursing facility had very little experience with Level II screens and they were "unaware" of this requirement. One facility in State 3 further explained: "We don't have anything specific—it's based on clinical judgment. If someone's mental status changes, we follow up with this. I don't know what the State considers to be a 'change in condition.'"

By contrast, nursing facility staff in States 1 and 4 appeared more familiar with change in condition criteria, with 67 percent of facilities in each State reporting established criteria. It is important to mention, however, that many of these nursing facilities indicated that change in condition criteria were developed to meet their MDS rather than PASRR requirements. For example, a nursing facility in State 4 responded, "We do monitor resident change in condition—positive or negative—because of MDS. We do take mental health into consideration as well." For those nursing facilities with established change in condition criteria, these criteria were most often described as changes in nursing facility resident behavior or cognitive status, such as suicidal ideation, aggressive outbursts, and confusion (see Exhibit 15).

Change in Condition Procedures. When asked to describe their protocol for handling the psychiatric decompensation of nursing facility residents, the most frequent response in States 2, 3, and 4 was to consult with a mental health professional. Discharging someone to a mental health treatment facility was the most common response for nursing facility staff in State 1. Less frequently, nursing facilities reported seeking consultations with nonmental-health–specific medical professionals and family (see Exhibit 41).

3. PASRR Oversight Mechanisms

The extent to which States have developed direct oversight systems to monitor PASRR implementation in nursing facilities can affect PASRR's impact on intended policy goals.

Nursing Facility Coordination and Communication With State. In States 1 and 4, nursing facility staff respondents typically described some familiarity with procedures for communicating with States about PASRR requirements as well as knowledge of the State's role in providing specialized services. In States 2 and 3, however, nursing facility staff respondents described much less familiarity in these areas (see Exhibit 42).

State Oversight of PASRR Screens. As presented in Exhibit 43, in States 1 and 4, the majority of nursing facility staff respondents reported that the State regularly monitors Level I and/or Level II screens and that State surveyors review PASRR documentation. This was particularly true in State 4. Respondents in States 2 and 3 were much less familiar with State monitoring activities, frequently responding "I don't know."

Exhibit 41: Change in Condition Issues for Nursing Facility Resident Record Review Sample (n=24)

Change in Condition Criteria	State 1 (n=6)	State 2 (n=6)	State 3 (n=6)	State 4 (n=6)
Yes	4 (67%)	0 (0%)	2 (33%)	4 (67%)
No	2 (33%)	6 (100%)	4 (67%)	2 (33%)
Change in Condition Procedures	**(n=6)**	**(n=5)**	**(n=6)**	(n=6)
Seek mental health consultation	3 (50%)	4 (80%)	6 (100%)	6 (100%)
Discharge to mental health treatment facility	6 (100%)	2 (40%)	5 (83%)	3 (50%)
Consult with primary care physician/medical staff	2 (33%)	1 (20%)	4 (67%)	2 (33%)
Consult with family	0 (0%)	1 (20%)	0 (0%)	1 (17%)

Exhibit 42: Coordination and Communication With State (n=24)

	State 1	State 2	State 3	State 4
State Communication Procedures	**(n=6)**	**(n=6)**	**(n=6)**	**(n=6)**
Some procedures	3	0	1	5
No procedures	3	6	5	1
Knowledge of State Role in Providing Specialized Services	**(n=6)**	**(n=6)**	**(n=6)**	**(n=6)**
Some familiarity described	4	0	0	4
Do not know how State handles this	2	6	6	2

Exhibit 43: State Oversight of PASRR Screens (n=24)

	State 1	State 2	State 3	State 4
Does State Regularly Monitor Level I or II Screens?	**(n=6)**	**(n=6)**	**(n=6)**	**(n=6)**
Yes	5	0	3	5
No	0	1	0	0
Do not know	1	5	3	1
Do State Surveyors Review PASRR Documentation?	**(n=6)**	**(n=6)**	**(n=6)**	**(n=6)**
Yes	3	0	2	4
No	1	2	0	0
Do not know	2	4	4	2

Exhibit 44: Effectiveness of State Oversight of PASRR Screens (n=24)

	State 1	State 2	State 3	State 4
Is Current PASRR Oversight System Effective?	**(n=6)**	**(n=3)**	**(n=6)**	**(n=5)**
Yes	3	2	2	0
No	2	1	4	3
Don't know	1	0	0	2
Could Current Oversight System Be Improved?	**(n=5)**	**(n=3)**	**(n=6)**	**(n=5)**
Yes	2	1	5	2
No	3	1	1	2
Do not know	0	1	0	1

Effectiveness of State Oversight of PASRR Screens. In State 1, staff respondents most frequently described the current oversight system as effective and not needing improvement. In State 2, the majority of nursing facility staff respondents described PASRR oversight as effective, but also indicated room for improvement. In States 3 and 4, the majority of respondents described their State's oversight system as not effective and needing improvement (see Exhibit 44).

C. PASRR Impact on Policy Goals

This section presents findings on the impact of PASRR on three important policy goals:

- Determining the extent to which PASRR assists in identifying serious mental illness in nursing facility applicants and residents
- Facilitating the availability and receipt of mental health services in nursing facilities
- Screening applicants and residents to ensure their appropriateness for nursing facility care

1. Overall Effectiveness of PASRR

Effectiveness of PASRR Programs. Exhibit 45 presents nursing facility staff ratings, by State, on the effectiveness of PASRR in achieving the policy goals enumerated above. In all four States, very few facility

Exhibit 45: Nursing Facility Staff Perceptions of PASRR Effectiveness (n=24)

	Poor	Fair	Good	Excellent
State 1				
Identifying individuals with serious mental illness (n=6)	2	1	3	0
Screening appropriateness for nursing facility care (n=6)	2	3	1	0
Ensuring provision of specialized services (n=6)	2	2	2	0
State 2				
Identifying individuals with serious mental illness (n=6)	1	4	1	0
Screening appropriateness for nursing facility care (n=6)	1	4	1	0
Ensuring provision of specialized services (n=5)	3	2	0	0
State 3				
Identifying individuals with serious mental illness (n=6)	0	1	4	1
Screening appropriateness for nursing facility care (n=5)	0	3	1	1
Ensuring provision of specialized services (n=5)	1	4	0	0
State 4				
Identifying individuals with serious mental illness (n=6)	3	1	2	0
Screening appropriateness for nursing facility care (n=4)	2	1	1	0
Ensuring provision of specialized services (n=4)	1	0	3	0

respondents rated PASRR as doing an "excellent" job achieving various outcomes. In States 1 and 3, the majority of nursing facility respondents rated PASRR in the "good" to "fair" range for various outcomes. Ratings in States 2 and 4 were slightly lower, with most respondents rating PASRR in the "fair" to "poor" range. Ratings on PASRR's ability to ensure the provision of specialized services tended to be lower, with State 4 being a notable exception.

2. Identification of Serious Mental Illness

To evaluate the extent to which PASRR has led to improved identification of serious mental illness among nursing facility applicants and residents, data are presented from both the larger sample of resident medical record reviews (n=786) and the subsample of clinical interviews (n=93).

a. Are Level II Screens Administered To Identify Nursing Facility Applicants With Primary Serious Mental Health Diagnoses?

Level II Screens and Nursing Facility Residents With Primary Mental Health Diagnoses Upon Admission. Exhibit 46 displays data on the subsample of individuals in each State who were given primary diagnoses of mental illness on admission. Examining their receipt of Level II screens and comorbid physical health diagnoses addresses PASRR's effectiveness in meeting intended policy goals of (a) identifying individuals with serious mental illness and (b) screening individuals who may not require nursing facility level of care, respectively. While States are expected to administer Level II screens to all nursing facility applicants with primary diagnoses of mental illness, data from the four-State sample indicate low levels of administration overall and considerable variation across States. No Level II screens were administered to individuals with primary mental health diagnoses in State 3, while State 1 administered Level II screens to 60 percent of individuals with primary mental health diagnoses.

It is also important to note that in our sample, most individuals with primary mental health diagnoses were also diagnosed with comorbid physical health conditions. Therefore, in our sample, even though Level II screens may not be administered consistently to individuals with primary diagnoses of mental illness, these individuals appear to have significant physical health conditions and are likely to meet nursing facility level of care requirements in the absence of mental health evaluations.

Exhibit 46: Nursing Facility Residents With Primary Mental Health Diagnoses at Admission (n=786)

	State 1 (n=215)	State 2 (n=213)	State 3 (n=177)	State 4 (n=181)
Primary Diagnosis of Mental Illness at Admission	**(n=25)**	**(n=11)**	**(n=19)**	**(n=21)**
Received Level II screen	15 (60%)	3 (27%)	0 (0%)	2 (10%)
Also diagnosed with physical health condition	23 (92%)	11 (100%)	15 (79%)	20 (95%)

b. Prevalence of Co-Occurring Dementia/Mental Health Conditions

PASRR Level II screens are not required for people diagnosed as having a primary diagnosis of dementia (unless mental retardation is present). However, a large proportion of the residents sampled had primary diagnoses of Alzheimer's/dementia and secondary diagnoses of mental health conditions (State 1=29 percent, State 2=40 percent, State 3=59 percent, and State 4=49 percent). This finding illustrates that PASRR cannot be considered to address all mental illness in nursing facilities.

c. Prevalence of Mental Illness (Severe and Less Severe) in Medical Chart Sample

Psychiatric Diagnoses. The percentage of individuals diagnosed with psychotic disorders upon admission ranged from 8 percent in State 2 to 17 percent in State 4. Therefore, these data suggest that nursing facilities in this sample are not admitting excessively high numbers of individuals with serious mental illness (that would meet the criteria of severity covered under PASRR). However, as shown in Exhibit 47, a significant number of residents do have psychiatric diagnoses that do not necessarily meet the PASRR severity criteria.

Exhibit 47 presents psychiatric diagnosis information across nursing facility resident records reviewed at two points in time: initial admission and currently (i.e., time of record review). In all four States, at initial admission and currently, the most frequently diagnosed psychiatric conditions were depressive disorders (e.g., major depression, dysthymia), followed by either psychotic disorders (e.g., schizophrenia, schizoaffective disorder) or anxiety disorders (e.g., obsessive-compulsive disorder, phobias). There appear to be relatively low numbers of individuals diagnosed with bipolar, substance abuse, and personality disorders in all four States. There was an increase in all psychiatric diagnoses (except for substance abuse and personality disorders) from initial admission to currently, which does suggest that many residents experienced significant changes in their mental condition over time. This could signal a problem in compliance with the statute since 1996 that requires a Level II screen whenever there is a significant change in the resident's physical or mental condition.

At the time of admission, between 42 and 61 percent of the resident records indicated a psychiatric diagnosis of any type. These numbers increased to between 53 and 81 percent at the time of the record reviews. These numbers are consistent with estimates from the National Nursing Home Survey (NNHS), which showed 66 percent of nursing facility residents have some type of mental disorder (Strahan & Burns, 1991). Further, 6–24 percent are estimated to have major depression, a particular serious mental illness that can respond to treatment (Cohen et al., 2003). In addition, some research indicates that close to two thirds of nursing facility residents are likely to have a mental disorder, although these figures include individuals with dementia as well as those with serious mental illnesses such as schizophrenia and major depression (Burns et al., 1993).

Dementia. Because they are excluded from statutory definitions of serious mental illness, individuals with a primary diagnosis of dementia, including Alzheimer's disease and related conditions, are not required to receive Level II screens. Across all four States, diagnoses of dementia-related

Exhibit 47: Psychiatric Diagnoses of Nursing Facility Resident Sample (n=786)

All Nursing Facility Residents	State 1 (n=215)		State 2 (n=213)		State 3 (n=177)		State 4 (n=181)	
	Initial	Current	Initial	Current	Initial	Current	Initial	Current
	(n=215)	(n=215)	(n=212)	(n=213)	(n=177)	(n=177)	(n=181)	(n=181)
Psychiatric Diagnoses	**100 (47%)**	**127 (59%)**	**89 (42%)**	**113 (53%)**	**82 (46%)**	**136 (77%)**	**110 (61%)**	**146 (81%)**
Depressive disorders	51 (24%)	81 (38%)	63 (30%)	85 (40%)	57 (32%)	109 (62%)	77 (43%)	113 (62%)
Psychotic disorders	23 (11%)	28 (13%)	17 (8%)	20 (9%)	24 (14%)	36 (20%)	31 (17%)	36 (20%)
Anxiety disorders	14 (7%)	26 (12%)	16 (8%)	19 (9%)	12 (7%)	39 (22%)	26 (14%)	38 (21%)
Bipolar disorders	12 (6%)	12 (6%)	3 (1%)	5 (2%)	4 (2%)	10 (6%)	12 (7%)	15 (8%)
Personality disorders	1 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (1%)	1 (1%)	3 (2%)	5 (3%)
Substance use disorders	6 (3%)	4 (2%)	3 (1%)	5 (2%)	8 (5%)	9 (5%)	20 (11%)	19 (10%)
Dementia-Related Conditions								
Alzheimer's disease/dementia	89 (41%)	105 (49%)	90 (42%)	92 (43%)	71 (40%)	100 (56%)	96 (53%)	111 (61%)

conditions at initial admission were found in 40–53 percent of the records reviewed (it was not possible to determine whether these were primary or secondary diagnosis). By the time of the record review, these numbers increased to between 43 and 61 percent of sampled residents (see Exhibit 47). These findings are consistent with literature indicating that roughly 50 percent of nursing facility residents have dementia on admission (Emerson Lombardo, 1994; Strahan & Burns, 1991).

3. Availability and Receipt of Mental Health Services

a. What Mental Health Services Are Available to Nursing Facility Residents?

Mental Health Services Available in Nursing Facilities. All participating nursing facilities across the four study States offered psychotropic medications, medication management, and consultation with mental health professionals (typically psychiatrists). Individual therapy/counseling was another frequently reported mental health service. Less frequently available services included developing behavior management plans, providing family education, and offering psychosocial rehabilitation services (see Exhibit 48).

Prescription of Psychotropic Medications. As presented in Exhibit 49, across all four States, 39–50 percent of residents were prescribed antidepressants upon initial admission, increasing to 62–65 percent at the time of the current record review.

Exhibit 48: Mental Health Services Available in Nursing Facilities (n=24)

Available Mental Health Services	State 1 (n=6)	State 2 (n=6)	State 3 (n=6)	State 4 (n=6)
Psychotropic medications/medication management	6	6	6	6
Consultation with mental health professionals	6	6	6	6
Individual psychotherapy/counseling	0	4	6	6
Behavior management/token economy	2	0	2	2
Family education	0	0	0	1
Socialization/recreation activities	2	0	1	2
Quality review/care team meetings	2	1	1	1
Day treatment/rehabilitation	0	1	0	2

Exhibit 49: Prescription of Psychotropic Medications for Nursing Facility Resident Record Review Sample (n=786)

Psychotropic Medications	State 1		State 2		State 3		State 4	
	Initial (n=209)	Current (n=215)	Initial (n=205)	Current (n=213)	Initial (n=79)	Current (n=177)	Initial (n=160)	Current (n=181)
Antidepressants	93 (44%)	135 (63%)	103 (50%)	137 (64%)	31 (39%)	109 (62%)	80 (50%)	117 (65%)
Antipsychotics	80 (38%)	92 (43%)	60 (29%)	71 (33%)	24 (30%)	77 (29%)	47 (29%)	70 (39%)
Anxiolytics	45 (22%)	51 (24%)	57 (28%)	85 (40%)	20 (25%)	71 (40%)	39 (24%)	49 (27%)
Mood stabilizers	21 (10%)	22 (10%)	7 (3%)	8 (4%)	14 (18%)	35 (20%)	18 (11%)	29 (16%)

Significant percentages of residents were prescribed antipsychotics or anxiolytics at the time of initial admission (ranging from 22 to 38 percent) and currently (ranging from 24 to 43 percent). Mood stabilizers were less frequently prescribed across all four States.

In all four States, there was an increase in prescriptions of all types of psychotropic medications (except for traditional antipsychotics) from the time of initial admission to the current record review. Percentage increases from admission to the current time period were generally comparable across all States:

- State 1 percentage increase: antidepressants (19 percent), atypical antipsychotics (7 percent), anxiolytics (2 percent)
- State 2 percentage increase:

antidepressants (14 percent), atypical antipsychotics (7 percent), anxiolytics (12 percent), and mood stabilizers (1 percent)
- State 3 percentage increase: antidepressants (23 percent), atypical antipsychotics (14 percent), anxiolytics (15 percent), and mood stabilizers (2 percent)
- State 4 percentage increase: antidepressants (15 percent), atypical antipsychotics (14 percent), anxiolytics (3 percent), and mood stabilizers (5 percent)

b. Are Nursing Facility Residents Receiving Mental Health Services?

Mental Health Services Ordered and Received. Based on an assessment of treatment activity over the previous 30 days, the most commonly ordered mental health services across all four States were psychotropic medication management and case consultation. There also was evidence in progress notes that ordered mental health services were actually received. In State 3, individual therapy was another commonly ordered and received mental health service, and in States 1 and 2, psychological testing/evaluation was received by a small number of residents (see Exhibit 50).

Mental Health Services and Medications by Psychiatric Diagnosis. As Exhibit 51 shows, when examined by specific type of psychiatric diagnosis, it is clear that the primary services that residents with mental health issues receive in all four States are medication review and case consultation. Residents with mental health issues in State 3 also received individual therapy (primarily those diagnoses with psychotic disorders, major depression, and anxiety).

Exhibit 50: Mental Health Services Ordered and Received for Nursing Facility Resident Record Review Sample (n=786)

	State 1 (n=215)		State 2 (n=213)		State 3 (n=177)		State 4 (n=181)	
Mental Health Services	**Ordered**	**Received**	**Ordered**	**Received**	**Ordered**	**Received**	**Ordered**	**Received**
Medication review	78 (36%)	110 (51%)	94 (44%)	123 (58%)	45 (25%)	45 (25%)	145 (80%)	147 (81%)
Psychological testing/ evaluation	0 (0%)	3 (1%)	9 (4%)	7 (3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Case manage-ment	1 (0%)	0 (0%)	0 (0%)	1 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Case consultation	90 (42%)	99 (46%)	89 (42%)	82 (38%)	16 (9%)	16 (9%)	56 (31%)	56 (31%)
Individual therapy	0 (0%)	0 (0%)	7 (3%)	7 (3%)	32 (18%)	33 (19%)	0 (0%)	0 (0%)
Other mental health services	2 (1%)	13 (6%)	5 (2%)	18 (8%)	0 (0%)	0 (0%)	1 (1%)	1 (1%)

Exhibit 51: Type of Service Received by Psychiatric Diagnosis

Current Diagnoses	State 1 (n=215)	State 2 (n=213)	State 3 (n=177)	State 4 (n=181)
Psychiatric Diagnoses	**(n=129)**	**(n=117)**	**(n=138)**	**(n=149)**
Psychotic Disorders	**(n=28)**	**(n=20)**	**(n=36)**	**(n=36)**
Medication review	19 (68%)	15 (75%)	15 (42%)	31 (86%)
Psychological testing/evaluation	1 (4%)	1 (5%)	0 (0%)	0 (0%)
Case management	0 (0%)	1 (5%)	0 (0%)	0 (0%)
Case consultation	16 (57%)	6 (30%)	8 (22%)	8 (22%)
Individual therapy	0 (0%)	1 (5%)	8 (22%)	0 (0%)
Other mental health services	2 (7%)	1 (5%)	0 (0%)	0 (0%)
Bipolar Disorders	**(n=12)**	**(n=5)**	**(n=10)**	**(n=15)**
Medication review	8 (67%)	5 (100%)	4 (40%)	12 (80%)
Psychological testing/evaluation	0 (0%)	1 (20%)	0 (0%)	0 (0%)
Case management	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Case consultation	8 (67%)	2 (40%)	3 (30%)	6 (40%)
Individual therapy	0 (0%)	0 (0%)	2 (20%)	0 (0%)
Other mental health services	2 (17%)	0 (0%)	0 (0%)	0 (0%)
Major Depressive Disorders	**(n=81)**	**(n=85)**	**(n=109)**	**(n=113)**
Medication review	40 (49%)	58 (68%)	29 (27%)	96 (85%)
Psychological testing/evaluation	0 (0%)	3 (4%)	0 (0%)	0 (0%)
Case management	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Case consultation	38 (47%)	40 (47%)	8 (7%)	44 (39%)
Individual therapy	0 (0%)	4 (5%)	25 (23%)	0 (0%)
Other mental health services	3 (4%)	9 (11%)	0 (0%)	1 (1%)

Exhibit 51 (Continued): Type of Service Received by Psychiatric Diagnosis

Current Diagnoses	State 1 (n=215)	State 2 (n=213)	State 3 (n=177)	State 4 (n=181)
Psychiatric Diagnoses	**(n=129)**	**(n=117)**	**(n=138)**	**(n=149)**
Anxiety Disorders	**(n=26)**	**(n=19)**	**(n=39**	**(n=38)**
Medication review	8 (31%)	13 (68%)	6 (15%)	28 (74%)
Psychological testing/evaluation	1 (4%)	1 (5%)	0 (0%)	0 (0%)
Case management	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Case consultation	(38%)	7 (37%)	0 (0%)	16 (42%)
Individual therapy	0 (0%)	2 (11%)	7 (18%)	0 (0%)
Other mental health services	2 (8%)	1 (5%)	0 (0%)	0 (0%)
Personality Disorders	**(n=0)**	**(n=0)**	**(n=1)**	**(n=5)**
Medication review	0 (0%)	0 (0%)	0 (0%)	5 (100%)
Psychological testing/evaluation	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Case management	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Case consultation	0 (0%)	0 (0%)	0 (0%)	1 (20%)
Individual therapy	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other mental health services	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Substance Use Disorders	**(n=4)**	**(n=5)**	**(n=9)**	**(n=19)**
Medication review	2 (50%)	4 (80%)	3 (33%)	14 (74%)
Psychological testing/evaluation	0 (0%)	1 (20%)	0 (0%)	0 (0%)
Case management	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Case consultation	2 (50%)	1 (20%)	1 (11%)	6 (32%)
Individual therapy	0 (0%)	2 (40%)	3 (33%)	0 (0%)
Other mental health services	0 (0%)	1 (20%)	0 (0%)	0 (0%)

c. What Mental Health Professionals Are Available to Nursing Facility Residents?

Availability of External Mental Health Specialists. As presented in Exhibit 52, some nursing facility staff respondents (about 38 percent) in States 1, 2, and 4 described some level of reluctance on the part of external mental health professionals (i.e., not on staff at the facility) to serve residents. Reasons for reluctance included not wanting to make visits outside their professional offices and a lack of specialized training in mental health issues. For example, one nursing facility in State 2 explained, "None are happy to come. . . . They are hesitant to leave their offices and sometimes have the perception that they cannot change older people."

Exhibit 52: Availability of Mental Health Specialists (n=24)

	State 1	State 2	State 3	State 4
Are Mental Health Specialists Reluctant To Serve Nursing Facility Residents?	**(n=6)**	**(n=6)**	**(n=6)**	**(n=6)**
Yes	3	3	0	3
Reasons for Reluctance	**(n=2)**	**(n=3)**	**(n=0)**	**(n=3)**
Do not want to see people outside their office	0	3	0	0
Do not have special training with geriatric populations	0	1	0	2
Medicaid/Medicare reimbursement issues	1	1	0	0
Overall scarcity of mental health professionals	1	0	0	1

Availability of Mental Health Professionals in Nursing Facilities. As illustrated in Exhibit 53, across the four States, there appear to be few mental health professionals on staff in the nursing facilities sampled. When on-staff mental health professionals are available, they are typically clinical social workers. Participating nursing facilities in all four States contract with a full range of mental health professionals, including psychiatrists, psychologists, and clinical social workers. In States 1 and 2, nursing facilities most frequently contract with psychiatrists, while in State 3, the most commonly contracted mental health professionals are psychologists. In State 4, a high percentage of nursing facilities also contract with clinical social workers.

Exhibit 53: Availability of Mental Health Professionals in Nursing Facilities (n=24)

	Staff	Contractors
State 1 (n=6)		
Psychiatrist	0	6
Psychologist	0	1
Clinical social worker	1	1
Other mental health professionals	0	3
State 2 (n=6)		
Psychiatrist	0	6
Psychologist	0	1
Clinical social worker	2	2
Other mental health professionals	1	1
State 3 (n=6)		
Psychiatrist	0	3
Psychologist	0	5
Clinical social worker	1	2
Other mental health professionals	0	0
State 4 (n=6)		
Psychiatrist	1	4
Psychologist	0	1
Clinical social worker	2	3
Other mental health professionals	1	3

Exhibit 54: Nursing Facility Staff Perceptions of Challenges to Treating Residents With Mental Illness (n=24)

Challenges Treating Residents With Mental Illness	State 1 (n=6)	State 2 (n=6)	State 3 (n=6)	State 4 (n=6)
Resident behavior	5	5	2	5
Nursing facility staffing/resource issues	2	2	3	3
Stigma/lack of understanding among family, staff	0	2	2	2
Lack of specialized providers	1	2	1	3
Difficult to coordinate mental health care with nonmental-health-care providers	2	1	1	0

Mental Health Training in Nursing Facilities. The majority of nursing facility staff respondents in all four States reported that staff received some level of mental health training, ranging from 5 out of 6 facilities in States 2 and 4, to 100 percent of participating facilities in States 1 and 3. Trainings were typically offered in-house and covered various topics, including recognizing and treating specific mental illnesses like depression, how to manage difficult behaviors, and working with residents with dementia or other cognitive impairments (see Exhibit 8 in Appendix A).

Challenges Faced by Nursing Facilities in Treating Individuals With Mental Illness. As presented in Exhibit 54, nursing facility staff in all four States most often highlighted difficult behaviors (e.g., aggressive outbursts, suicidality) as the most challenging aspect of treating residents with mental illness. In the words of one nursing facility respondent in State 4, "The challenge is to get people stable and have a normal-type resident. . . . It can take a long time to get appropriate medications." Nursing facility staffing and resource issues (e.g., lack of resources to provide mental health services within nursing facilities, understaffing, etc.) were also frequently reported challenges in all States. Respondents in States 2, 3, and 4 also mentioned the role that stigma can play in serving residents with mental illness. One facility in State 3 described attempting to address this issue proactively, noting that "[it is important] to educate family members about dementia, depression, and anxiety in regard to the disease process and how to deal with behavior changes."

D. PASSR Issues Identified From the Clinical Interview Sample

A further goal of the in-depth four-State study was to obtain a subsample of nursing facility residents from the medical chart sample in two States and conduct clinical interviews with a total of no more than 100 of those residents. Several objectives were achieved:

- Identification of those with the most severe illness in the clinical interview subsample
- Assessment of performance of Level I and II screens in sample
- Assessment of mental health services ordered and received for sample
- Assessment of diagnoses and psychotropic drug medications in sample

1. Reviewing Method of Obtaining Interview Sample

The clinical interview sample was pulled from the two States' medical chart sample to yield a total of 93 residents. The clinical interview sample selection (a subset of the medical chart sample) is described in more depth on pages 18 and 51. Briefly, the 93 interviewed residents were selected randomly from two States in the larger medical record chart sample, previously described on pages 17–18. In those two States, about 7–9 interviewees per facility were pulled randomly from the medical chart sample.

It should be noted the original, larger medical record sample in all four States, of which 786 charts were examined (almost 40 from each of 6 facilities in each of 4 States), was purposively biased to identify and capture those residents most likely to have mental illness. The purpose was to evaluate if those with mental illness were receiving the Level II screen as required and services they needed, and to determine if they were appropriately placed in nursing facilities.

To draw the larger medical chart sample, first all charts of residents who received a Level II screen were pulled; then, those currently prescribed psychotropic medications; and lastly, those positive for any primary or secondary diagnosis on any mental illness. From this group, up to 40 charts per facility were pulled randomly for the medical chart review (n=786). From the chart review group, a subset to clinically interview was randomly selected (n=93). Thus, all those 93 residents interviewed would be expected to have some level of mental illness.

2. Exhibits Overview

The five exhibits (Exhibits 55–59) describing the clinical interview sample show composite data for 93 residents from two States and are displayed in each exhibit as two separate groups:

- Those 61 residents who scored below the cutoff scores for significant symptoms of mental illness based on any of the three clinical screening instruments: Brief Symptom Inventory (BSI), the Geriatric Depression Scale (GDS), and the Short-Form Health Survey (SF-12), and
- Those 32 residents who scored above the cutoff score on any of the three clinical tests

Due to the method of obtaining the medical chart sample and the subsample of those selected to interview, all participants in the clinical interview would be expected to have a likelihood of mental illness. Those 32 individuals scoring beyond the cutoff were judged likely to have serious psychopathology. Nevertheless, this judgment emanated from scores on these screening instruments and was not validated by an independent, formal clinical assessment.

3. Validity and Reliability for the Three Clinical Screening Instruments To Identify Residents With Significant Mental Illness

The residents were given five mental health screens, described on page 20. Based on a review of the psychometric properties of these screens, scores on three of these instruments were used to identify residents showing significant symptoms consistent with diagnoses of mental illness: the Brief Symptom Inventory (BSI), the Geriatric Depression Scale (GDS), and the Short-Form Health Survey (SF-12).

To be consistent with a cutoff score across all three measures, a percentile rank of 90 (equivalent to a T-score of 63) was identified as the statistical marker of significant mental

illness. Residents who scored in the top 10th percentile on any of these three measures of psychiatric symptoms were identified as scoring above the cutoff and were considered to have the highest probability of serious mental illness. The specific cutoff scores for each measure were identified as—

1. A BSI T-score greater than or equal to 63, or
2. An SF-12 Transformed Mental Score less than or equal to 37, or
3. A GDS score of 10 or above.

Of the 32 residents judged to have serious psychopathology, 30 scored above the cutoff on 2 or more screening instruments.

a. Brief Symptom Inventory

The BSI T-score cutoff of 63 or above was based on the definition provided in studies and established by the BSI Procedures Manual (Derogatis, 1993):

> *The operational rule for caseness provided above states that if the respondent has a GSI score (on Norm B, the adult nonpatient norm) greater than or equal to a T score of 63, or if any two primary dimension scores are greater than or equal to a T score of 63, then the individual will be considered a positive diagnosis or a case* (Derogatis, page 32).

b. Short Form-12

The SF-12 asks 12 questions: 6 questions are on the individual's physical health, and 6 questions are on the mental health of the individual. The SF-12 uses norms developed on noninstitutionalized adults and has one T-score that combines the 6 mental health items into a single normed score called the "Transformed Mental Score." A T-score of 37 or lower on the Transformed Mental Score is at the 90th percentile, corresponding to the extreme 10 percent of the normal population on a bell curve. In this screen, the lower the score, the more likely there is an illness.

c. Geriatric Depression Scale

The GDS uses T-scores to divide respondents into three categories of "normal," "mild depression," and "severe depression." A positive case was defined as "severe depression" in the clinical interview sample.

The Interview Sample and Exhibits

All 93 interviewees were from the purposively biased sample, identified by the medical chart review sample as more likely to have a mental illness. The 32 residents with the most severe symptoms identified from the interviews are represented in the 5 following exhibits as those "equal to or above the cutoff." Thus, one would expect those individuals to be the most likely to have severe mental illness and receive the highest rate of Level I and Level II screens, as well as mental health services.

4. Demographics of the Clinical Interview Sample

Exhibit 55 shows the demographics of the clinical interview sample. The group as a whole was relatively similar to the larger medical chart sample from which the interview sample was pulled (see Exhibit

Exhibit 55: Demographics of Clinical Interviewees

Demographics	Both States n=93	
	Composite Score*	
	< cutoff	≥ cutoff
	(n=61)	(n=32)
Age	**(n=59)**	**(n=32)**
18–64	7 (11.9%)	6 (18.8%)
65–79	14 (23.7%)	9 (28.1%)
80–84	13 (22%)	0 (31.3%)
85–90	17 (28.8%)	4 (12.5%)
>90	8 (13.6%)	3 (9.4%)
Gender	**(n=61)**	**(n=32)**
Female	40 (65.6%)	28 (87.5%)
Male	21 (34.4%)	4 (12.5%)
Marital Status	**(n=61)**	**(n=32)**
Single/Never Married	6 (9.8%)	7 (21.9%)
Married	12 (19.7%)	7 (21.9%)
Divorced/Separated	5 (8.2%)	6 (18.8%)
Widowed	38 (62.3%)	12 (37.5%)
Race/Ethnicity	**(n=58)**	**(n=31)**
White	56 (96.6%)	29 (93.5%)
Non-White	2 (3.4%)	2 (6.4%)

* Individuals considered more likely to have mental illness if they have—
1. A BSI t-statistic greater than or equal to 63,
2. An SF-12 "transformed mental" score less than or equal to 37, or
3. A GDS score of 10 or above.

38). The age spread included a significant number of individuals over 80 years of age (53–64 percent); mainly female in gender; and more predominantly widowed, rather never married/divorced. In ethnicity, the sample was over 93 percent White.

5. PASRR Level I and II Screens

All admissions to a nursing facility should have received the Level I screen for potential mental illness, but our clinical sample received a rate between 72 and 79 percent. Those scoring above the cutoff were clinically very symptomatic; thus, all should have received the Level II PASRR screens as well. However, less than 10 percent had evidence in their charts of receiving a Level II screen. Exhibit 56 shows that 76 percent of those interviewed got a Level I screen, and only 7 percent of all those interviewed received a Level II screen—an inexplicably low PASRR screening rate.

Exhibit 56: PASRR Level I and II of Clinical Interviewees

	Both States n=93	
	Composite Score*	
	< cutoff	≥ cutoff
PASRR Screens	**(n=61)**	**(n=32)**
Level I	48 (78.7%)	23 (71.9%)
Level II	4 (6.6%)	3 (9.4%)

* Individuals considered more likely to have mental illness if they have—
1. A BSI t-statistic greater than or equal to 63,
2. An SF-12 "transformed mental" score less than or equal to 37, or
3. A GDS score of 10 or above.

6. Current Diagnoses of Clinical Interviewees

Within the sample, only 64 percent of the 93 residents interviewed were identified in their charts as having a current psychiatric diagnosis. As shown by Exhibit 57, at least 34 per cent had no mental illness diagnosis, even though this sample was from the most severe mentally ill residents; yet all were on some type of psychotropic medication.

Among those with a diagnosis, major depressive disorders were the most common in both groups. Only 16 percent had a diagnosis of Alzheimer's or dementia.

Psychiatric History of Clinical Sample. About one third of the residents clinically interviewed reported previous contact with mental health professionals; less than one quarter reported previous inpatient hospitalization (see Exhibit 7 in Appendix A).

7. Current Psychotropic Medications

Nearly all of the residents clinically interviewed received psychotropic medication, but 34 percent did not have a psychiatric diagnosis. Although Exhibit 57 shows 60–70 percent overall rate in identified psychiatric diagnoses, the rate of current psychotropic medications was virtually at 100 percent in the more symptomatic clinical group, and over 95 percent for the rest of the clinical sample (Exhibit 58). Antidepressant medication rate was above 70 percent in both clinical groups, yet exhibit 57 shows a diagnosis of major depression at a rate of only 37–52 percent.

Exhibit 57: Major Categories of Diagnoses of Clinical Interviewees,Currently

Demographics	Both States n=93	
	Composite Score*	
	< cutoff	≥ cutoff
Currently	**(n=61)**	**(n=32)**
Psychiatric Diagnoses	41 (67.2%)	19 (59.4%)
Psychotic disorders	7 (11.5%)	5 (15.6%)
Bipolar disorders	3 (4.9%)	2 (6.3%)
Major depressive disorders	32 (52.5%)	12 (37.5%)
Anxiety disorders	6 (9.8%)	3 (9.4%)
Personality disorders	0 (0%)	0 (0%)
Substance use disorders	1 (1.6%)	1 (3.1%)
Dementia-Related Conditions		
Alzheimer's disease/dementia	11 (18%)	4 (12.5%)

Note: Categories are not mutually exclusive
* Individuals considered more likely to have mental illness if they have—
1. A BSI t-statistic greater than or equal to 63,
2. An SF-12 "transformed mental" score less than or equal to 37, or
3. A GDS score of 10 or above..

8. Mental Health Services Currently Ordered and Received in Last Month for Interviewees

Exhibit 59 shows that in this sample of 93 residents with probable mental illness and on psychotropic medications, a significant percent received no mental health services in the previous 30 days—not even medication review. Of those individuals receiving services, the services were almost entirely limited to medication review and case consultation. No psychosocial rehabilitation services, no individual or group therapy, no behavior therapy, and no crisis intervention were being delivered to this subsample of residents with a high likelihood of having mental illness.

9. Summary of Clinical Interview Sample

A subset of nursing facility residents from two States, purposively drawn to select those more likely to have mental illness, was interviewed using clinical screening tests. Of 93 residents interviewed, about one third (32) scored on clinical screening instruments as most definitely having psychopathology. Yet, few of those interviewed appeared to have received a mandated Level II PASRR screen (less than 10 percent of those above the cutoff). Nearly all were receiving

Exhibit 58: Current Psychotropic Medications of Clinical Interviewees

Psychotropic Medications	Both States n=93	
	Composite Score*	
	< cutoff	≥ cutoff
Currently	**(n=61)**	**(n=32)**
Traditional antipsychotics	3 (4.9%)	0 (0%)
Atypical antipsychotics	6 (9.8%)	10 (31.3%)
Antidepressants	44 (72.1%)	23 (71.9%)
Anxiolytics	18 (29.5%)	14 (43.8%)
Mood stabilizers	4 (6.6%)	3 (9.4%)
Other medications	6 (9.8%)	2 (6.3%)
Any Psychotropic Medications	58 (95.1%)	32 (100%)

* Individuals considered more likely to have mental illness if they have—
1. A BSI t-statistic greater than or equal to 63,
2. An SF-12 "transformed mental" score less than or equal to 37, or
3. A GDS score of 10 or above.

psychotropic medications, yet barely half had a mental diagnosis, and virtually none was receiving any mental health services other than some limited medication review and case consultation. In fact, a significant portion had received no mental health service in the previous 30 days, not even medication review.

E. PASRR Issues Identified at the Nursing Facility Level

A final goal of the in-depth State studies was to identify key issues and concerns regarding actual implementing PASRR at the nursing facilities. Throughout this section, data and qualitative evidence are integrated from nursing facility staff interviews (n=24).

1. Nursing Facility Staff Respondent Perceptions of PASRR

Administrative Burden. In all four States, the majority of nursing facility respondents said that PASRR did not increase administrative burden—with States 1 and 3 at 67 percent, and States 2 and 4 at 100 percent (see Exhibit 10 in Appendix A).

Use of PASRR. To assess how nursing facilities are using PASRR, nursing facility staff respondents were asked to describe the purpose of PASRR in their facility. Exhibit 56 presents data on nursing facility staff responses to the question, "How is PASRR used at your facility?" In States 1 and 3, most respondents described PASRR as a required screening tool that assists them in making admissions decisions. For example, a typical response included, "[PASRR is used]

Exhibit 59: Mental Health Services Currently Ordered and Received in Last 30 Days of Clinical Interviewees

Mental Health Services	< Cutoff* – Both States		≥ Cutoff* – Both States	
	Composite Score*		Composite Score*	
	Ordered	Received	Ordered	Received
Currently	**(n=61)**	**(n=61)**	**(n=32)**	**(n=32)**
Medication review	26 (42.6%)	29 (47.5%)	10 (31.3%)	18 (56.3%)
Psychological testing/evaluation	4 (6.6%)	3 (4.9%)	0 (0%)	1 (3.1%)
Case management	1 (1.6%)	0 (0%)	0 (0%)	0 (0%)
Case consultation	27 (44.3%)	24 (39.3%)	13 (40.6%)	10 (31.3%)
Psychiatrist	15 (24.6%)	10 (16.4%)	10 (31.3%)	6 (18.8%)
Psychologist	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other mental health professional	13 (21.3%)	15 (24.6%)	3 (9.4%)	4 (12.5%)
Psychosocial rehabilitation services	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Individual therapy	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Group/Family therapy	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Behavior management/therapy	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Psychoeducation	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Outpatient services	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Day treatment/partial hospitalization	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Crisis intervention	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Other mental health services	1 (1.6%)	5 (8.2%)	1 (3.1%)	1 (3.1%)

* Individuals considered more likely to have mental illness if they have—
1. A BSI t-statistic greater than or equal to 63,
2. An SF-12 "transformed mental" score less than or equal to 37, or
3. A GDS score of 10 or above.

to determine whether or not placement is appropriate. We do have some residents with mental retardation/developmental disabilities or mental illness, but there have to be other complex medical issues going on. The PASRR process determines this."

By contrast, all six respondents in State 2 and half of State 4 respondents did not consider PASRR to be useful, viewing it as a mandatory paperwork requirement. In the words of one nursing facility staff in State 3, "PASRR is simply a piece of paper—a

requirement. We already know what the history is because we get this as part of our admissions packet." Despite conflicting views of PASRR's overall purpose and utility, the majority of nursing facilities have incorporated PASRR into overall facility operations by assigning PASRR responsibility to a designated staff member, typically the admissions nurse or a social worker (see Exhibit 5 in Appendix A).

PASRR and Nursing Facility Admissions. As presented in Exhibit 57, in nursing facility staff interviews, the majority of respondents from States 1, 3, and 4 described PASRR's impact on the admissions process as one that primarily involves ensuring that PASRR paperwork is completed. One respondent in State 1 highlighted payment issues as an incentive for completing paperwork: "The PASRR screen needs to be completed in order to receive payment from Medicaid." A majority of respondents in States 3 and 4 also reported that special attention is paid to whether or not the nursing facility can handle the needs of residents with mental illness. For example, in State 3, one staff person described PASRR as important for their facility because staff lack mental health expertise: "If the PASRR form indicates mental illness, we try to understand what they have to see if we can handle it, since we are not a strong mental health facility." In State 2, the majority of respondents described their nursing facilities as reluctant to accept individuals with mental illness. A typical response was that "they are really at the end of the waiting list in terms of acceptance to the facility." Across all four States, the majority of nursing facility staff respondents reported that the admissions process does not differ substantially depending on age and that individuals with mental illness are not physically separated from other residents in any way (see Exhibit 9 in Appendix A).

2. Recommendations for Improving PASRR

Recommendations for Improving State Oversight. Few facilities offered suggestions for ways to improve State oversight of the PASRR process (see Exhibit 58). Those responding frequently highlighted the need for increased State training on PASRR policy and procedures. In State 1, the majority of respondents also advocated the need for increased funding and resources for nursing facilities to treat mental illness among residents.

Exhibit 60: Nursing Facility Staff Perceptions of Usefulness of PASRR (n=24)

Purpose/Utility of PASRR	State 1 (n=6)	State 2 (n=6)	State 3 (n=6)	State 4 (n=6)
Not useful, mandatory paperwork	2	6	0	3
Useful, required screening tool	4	0	6	3

Exhibit 61: PASRR Impact on Admissions Process (n=24)

PASRR's Impact on Admissions Process for Individuals With Mental Illness	State 1 (n=6)	State 2 (n=6)	State 3 (n=6)	State 4 (n=6)
Make sure PASRR paperwork is complete	6	2	4	4
Special attention to assessing whether nursing facility can meet mental health service needs	2	2	4	5
Reluctant to accept individuals with serious mental illness or difficult-to-manage behaviors	1	4	1	0

Exhibit 62: Recommendations for Improving State Oversight of PASRR (n=63)

Recommendations for Improving State Oversight of PASRR	State 1 (n=5)	State 2 (n=1)	State 3 (n=5)	State 4 (n=2)
PASRR screens should provide more detailed information about mental illness	1	1	0	0
Reinstate annual review requirement	1	0	2	0
Require State surveyors to review PASRR documentation	1	0	2	0
More State training on PASRR	2	0	3	1
More funding/resources for treatment of mental illness in nursing facilities	3	0	0	1

VII. Conclusions

A. Summary of National Survey Findings

1. PASSR Policies and Procedures at the State Level

There is significant State variation in the administration and implementation of PASRR. States vary in the way they organize and distribute PASRR responsibilities among agencies. Although considerable flexibility is afforded to States in organization and delegation of functions, Federal law and regulations specifically delineate PASRR roles for Medicaid agencies and SMHAs. However, only 27 States reported dividing PASRR responsibilities between these two agencies. The entities responsible for conducting PASRR screening also vary considerably across States. For Level I screens, most States allow referral sources (e.g., acute care facilities, rehabilitation hospitals) and nursing facilities to complete evaluations. In 20 percent of the States, however, this function is completed by a State agency, while 16 percent of the States contract with various public and private entities to complete these screens. For Level II screens, most State agencies contract with an independent entity, but the type of contracted entity ranges from private mental health organizations to local public mental health authorities to individual practitioners. In addition, there are several States that allow a State agency other than the SMHA to make PASRR determinations.

Change in condition criteria and notification procedures also vary across States. With the elimination of the annual resident review requirement in 1996, States were required to develop criteria and procedures for identifying when nursing facility residents experience a significant change in condition to trigger a Level II review. While all States have developed procedures for identifying significant changes in condition (for example, use of the MDS [53 percent], specific behavioral/functional criteria, requirements for nursing facilities to notify the State), some, such as use of Level I criteria are inappropriate for this purpose. There is evidence that rates of compliance with the change in condition requirement may be low, which is consistent with the finding of the PASRR study conducted by OIG (2001).

2. PASRR Impact on Intended Policy Goals

While most State Medicaid agencies cover the cost of providing basic mental health services in nursing facilities, many respondents expressed concerns about access to and quality of mental health services. In 38 of 42 States, the Medicaid nursing facility benefit covers basic psychiatric consultation services, such as medication monitoring by a psychiatrist or individual counseling by a social worker, but few cover more intensive mental health rehabilitation services that are effective for people with serious mental illness. Furthermore, up to one third of State

respondents reported that nursing facility resident access to mental health services is limited and of variable quality. This calls into question whether determinations of need for nursing facility services are facility-specific, as required (that is, that the admitting nursing facility offers the specific services the individual requires).

PASRR agencies are minimally involved in monitoring of PASRR outcomes. Respondents at State PASRR agencies involved with PASRR rarely described their agency as having responsibility for overseeing nursing facility implementation of PASRR evaluations and determinations and recommendations. Instead, over three quarters of States reported that oversight was handled by the State entity that conducts survey and certification of nursing facilities (which is not one of their functions). Very few States have developed quality review processes to ensure that PASRR screens are completed accurately.

Community-based alternatives to institutional care are available in most States. Over 80 percent of States reported the availability of community-based mental health residential programs, and 36 percent mentioned assisted living with mental health services and other senior residential programs as alternatives to nursing facility care. Nevertheless, most survey respondents emphasized that demand for such alternatives tends to outpace current availability of these alternative options. States are not offering home and community-based (waiver) mental health services for the 21–65-year-old population because Medicaid rules forbid using institutions for mental illnesses as the institutional alternative. Interestingly, PASRR data could help to establish nursing facilities as the institutional basis for mental health waiver services, but States did not describe doing so.

PASSR is underutilized in Olmstead planning. Perhaps reflecting the fact that the Olmstead ruling has been applied more consistently to younger populations, only about a quarter of States actively consider PASRR as part of their planning to serve individuals with disabilities in the most community-integrating setting.

3. State-Level Issues Identified Through PASRR Implementation

PASRR is considered effective and generally meets policy goals. Most respondents rated PASRR as doing a "good" job of meeting its main policy goals of identifying individuals with serious mental illness, screening appropriateness for nursing facility care, and ensuring provision of specialized services. About half also reported that it has positively affected the type, amount, and quality of mental health services in their State.

Lack of State oversight is highlighted as main PASRR weakness. When identifying specific weaknesses of their State PASRR programs, respondents most frequently cited gaps in oversight, which included limited State activity related to PASRR enforcement and the absence of punitive disincentives for enforcing nursing facility compliance. Lack of agency coordination was also cited.

Survey respondents generated recommendations on how to improve PASRR for CMS, State PASRR agencies, and nursing facilities. Respondents called for more guidance and involvement by CMS, particularly in clarifying various regulations and payment issues. They highlighted the need for both CMS and State PASRR agencies to strengthen oversight, and they

stressed the need to expand educational activities at the State level and within nursing facilities to improve knowledge of PASRR programs and mental health/behavioral issues.

Lack of resources are perceived as biggest barrier to change. Nearly all States are currently experiencing budget difficulties that necessitate hard decisions about where agencies can trim back to save money. Most respondents felt that improving PASRR would require more financial (as well as nonfinancial) resources than States are willing or able to provide.

B. Summary of In-Depth State Study Findings

1. PASRR Policies and Procedures at the Nursing Facility Level

Many nursing facilities do not consider PASRR to be a useful tool. Nursing facility staff respondents were equivocal in their views of the utility of the PASRR process. Nearly half (46 percent) viewed the process as mandatory paperwork that does not enhance the admissions process. This is not surprising since Level II evaluations and determinations that should guide care were often not even present in the resident's record. However, the other half described the process as a valuable approach for determining the appropriateness of a nursing home placement. The nursing facilities were also mixed in their views regarding State oversight of the PASRR process, with a third of the staff viewing the oversight process as effective and more than 40 percent indicating the oversight system could be improved. Only a third of the nursing facilities reported regular State monitoring of Level I and Level II screens.

Level I screens are well documented in charts. Compared to the OIG study that found Level I documentation in fewer than 50 percent of the charts reviewed, relatively high percentages of Level 1 screens were found in the charts reviewed, ranging from 71 to 93 percent across the four States.

Nursing facility staff in many facilities are unfamiliar with change in condition criteria for triggering a PASRR Level II resident review. More than half (58 percent) of the nursing staff respondents were unfamiliar with the change in condition requirement and could not describe the criteria used in their States to trigger a PASRR review. Levels of awareness and knowledge of the change in condition criteria varied across and within the four States; however in one State, no respondents could describe the specific criteria used. Few Level II change in condition resident reviews were documented in medical records.

Investments in Level II evaluations are variable and underutilized. In the sample states and in the national survey, states demonstrate the capacity to perform Level II evaluations. However, Level II preadmission evaluations and determinations are not being adequately completed for those with mental illness, as required (Exhibits 46 and 56). Even when they are done, the information is used less frequently to guide ongoing treatment and services for individuals after they become nursing facility residents. Level II evaluations (as required by the Balanced Budget Act [BBA] of 1996) are performed or documented even less frequently when needed to reassess residents who experience a change in condition or mental or physical status.

Nursing facility workers and state respondents indicate that these deficits are the result of the lack of clear policy, little oversight or training, and insufficient resources. However, since Level II evaluations for resident review are identical to preadmission screenings (PAS) (which are being performed), it appears that there is existing capacity to perform resident review that is underutilized by nursing facilities. The process apparently missing is the integration of available PAS information by nursing facilities into their treatment planning and reassessment process.

Developing a PASRR tracking system for nursing facilities would be burdensome, and possibly unnecessary, if the MDS (Minimum Data Set) process can include PASRR. Nursing facilities are invested in and compliant with the MDS, which is a comprehensive process for evaluating and tracking resident condition, changes in condition, and needed services. Federal regulations encourage closely linking PASRR to the MDS, and 53 percent of states refer to the MDS in their PASRR change of condition procedures. Further study is indicated to determine whether there is a means to connect the existing state investments in Level II PAS, the apparent available capacity to perform Level II RR, and nursing facility investment in the ongoing MDS process as a cost-effective means to correct the observed deficiencies in PASRR.

2. PASRR Impact on Intended Policy Goals

The ability of the PASRR screening process to effectively identify individuals with serious mental illness varies across the four study States. Averaged across all 4 States, 50 percent of records reviewed indicated some type of psychiatric diagnosis at the time of admission, most of which were depressive (60 percent) or psychotic (24 percent) disorders. Fewer records (12 percent or less across all four States) identified individuals with a primary diagnosis of mental illness upon admission, yet not all of these individuals received PASRR Level II screens. Of great concern is the considerable variability across study States in the extent to which Level II screens were administered to individuals with primary diagnoses of mental illness, ranging from 0 percent in one State to a high of 60 percent in another State.

In the medical records reviewed, diagnoses of mental illness increased over the course of stay in the nursing facility, indicating that levels of depression and psychiatric/behavioral problems are associated with length of stay. Clinical interviews indicated serious psychopathology among 34 percent of those interviewed and few of those who needed it got a Level II (PASRR) screen or mental health services.

Nearly half of nursing facility residents had diagnoses of dementia. At time of admission, 18 percent of residents on average had a primary diagnosis of dementia, but almost half were diagnosed with a nonprimary dementia-related condition at admission. Federal guidelines exclude many individuals with dementia from the PASRR process, missing significant mental health needs. This policy bears further examination.

In the four study States, the PASRR process appears effective in identifying individuals who do not require nursing facility level of care. Medical record data from our sample indicate that nearly all nursing facility admissions (96 percent) had a primary or secondary physical health diagnosis. In addition, most people had

multiple medical conditions—between four and nine in all four States, with the most common diagnoses including disorders of the nervous, circulatory, and musculoskeletal systems. Health status data also indicate that individuals from the clinical sample currently experience significant physical health impairments. Furthermore, of those individuals with primary mental health diagnoses, 91 percent had additional physical health diagnoses upon admission across all four States.

In the four study States, the PASRR process alone does not ensure that people receive mental health services. While all 24 nursing facilities studied provide some mental health services (primarily medication monitoring and psychiatric consultation services), the availability of other mental health services, such as individual counseling or behavior management plans, varies across States and facilities. Only 20 percent of the facilities offer quality review and care team meetings for mental illness treatment. The majority (62 percent) of the nursing facilities indicate that treating persons with mental illness is challenging, primarily because of behavioral issues, and cited a lack of resources, including staff, as barriers to dealing effectively with this population. These findings suggest that PASRR determinations are not facility-specific, as required; that is, a judgment that a particular nursing facility can provide the exact services an applicant requires. In one State, the majority of nursing facilities indicate a reluctance even to admit persons with serious mental illness because of their behavioral issues.

3. PASRR Implementation Issues at the Nursing Facility Level

Procedures for communicating PASRR outcomes are unclear to many nursing facilities. Nursing facilities in most of the States studied indicate a lack of familiarity with how to communicate to State agencies about PASRR outcomes and change in condition criteria. Many facilities are not aware of State oversight procedures.

There appear to be issues with notification of significant change in condition. Nursing facility staff appear less familiar with the requirement to perform a Level II resident assessment whenever there is a change in a resident's mental or physical condition. More training, oversight by CMS, and linkage with the MDS would be helpful.

Nursing facility staff ratings of PASRR effectiveness are low compared to State-level administrators. The majority of nursing facility staff rate the effectiveness of PASRR as fair to poor in three areas: identifying individuals with serious mental illness, screening appropriateness for nursing facility level of care, and ensuring the provision of specialized services. However, the majority did not find PASRR to be an administrative burden.

VIII. Glossary

BBA – Balanced Budget Amendment
BOMC – Blessed Orientation-Memory-Concentration Test (screens for dementia)
BSI – Brief Symptom Inventory (test to rate emotional distress)
CMS – Centers for Medicare & Medicaid Services
CMHS – Center for Mental Health Services
DHHS – Department of Health and Human Services
DQoL – Dementia Quality of Life instrument
DSM – Diagnostic and Statistical Manual of Mental Disorders
GAO – General Accounting Office
HCBS – Home and Community-Based Services (Medicaid waivers)
IMD – Institute for Mental Disease
IOM – Institute of Medicine
Level I PAS Screen – Identifies, prior to admission, nursing facility applicants who might have serious mental illness
Level II PAS Screen – More extensive screen, prior to admission, for nursing facility applicants who are suspected of having a serious mental illness
MDS – Minimum data set
MSA – Metropolitan statistical area
OBRA – Omnibus Budget Reconciliation Act
OIG – The Office of the Inspector General
Olmstead – The Olmstead Supreme Court decision mandates that States "provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate."
PAS – Preadmission Screening
PASARR – Preadmission Screening and Annual Resident Review (prior to 1996)
PASRR – Preadmission Screening and Resident Review (sometimes referred to in parts as PAS and RR)
QMHP – Qualified mental health professionals
RR – Resident Review
SAMHSA – Substance Abuse and Mental Health Services Administration
SF-12 – Short-Form Health Survey (test to assess perceived health)
SMHA – State Mental Health Authorities
SSWLHC – Society for Social Work Leadership in Health Care

IX. References

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X. Appendices