GENERAL DISTRIBUTION

WEST VIRGINIA
DIVISION OF CORRECTIONS
& REHABILITATION

NUMBER: **427.00**

DATE: **14 December 2020**

SUBJECT: **NURSING HOME PRE-ADMISSION SCREENING (PAS)**

POLICY DIRECTIVE

PURPOSE:

To identify the procedures for completing the Nursing Home Pre-Admission Screening process for appropriate inmates.

REFERENCE:

WV Medicaid Policies and Procedures; and WV Code §16-30-8.

RESPONSIBILITY:

No additional written instructions on this subject are required.

CANCELLATION:

Any previous written instruction on the subject.

APPLICABILITY:

All facilities within the Division of Corrections and Rehabilitation (DCR) that have custody of adult inmates. This Policy is available for general distribution.

DEFINITIONS:

KEPRO: An Administrative Service Organization contracted by the WV Department of Health and Human Resources (WVDHHR) as the agent of the Bureau of Medical Services, Bureau for Children and Families, and Bureau for Behavioral Health Services.

POLICY:

I. Reentry Coordinators, or other appropriate staff designated by the Superintendent, shall be responsible for coordinating with facility medical staff to complete the Nursing Home Pre-

Admission Screening (PAS) form for those inmates who are potential nursing home patients and may not have viable living arrangements upon the inmate's release.

A. Medical staff shall have the primary task of completing the PAS form and providing appropriate documentation.

B. Reentry Coordinators (or other Superintendent-designated staff member) shall be responsible for tracking the progress and ensuring the timely completion of the required paperwork.

II. Completed PAS forms should be submitted sixty (60) days prior to the inmate's expected release date.

A. PAS forms are available on KEPRO'S website at http://wvaso.kepro.com/media/2166/blank-pas-form.pdf

1. Completed forms can be submitted by data entry via https://c3.kepro.com/cms/main; OR

2. Completed forms can be submitted to KEPRO via FAX 1-844-633-8425. The ID number should be included on top of the faxed form.

3. If the submitter desires to submit electronically a web user request form must be completed and approved. The form is available at http://wvaso.kepro.com/media/1949/nursing-facility-c3-pas-web-user-request-form-20160809.pdf

B. The submitter is considered the "Referral From." The "Referral To" is only designated when a bed is confirmed at a nursing home facility.

C. Submitting supporting documentation cuts down on human error and makes the application process more efficient.

D. Signatures from the Applicant/Applicant Representative and Physician (M.D. or D.O.) must be obtained on hard copy, regardless if hand-writing form or a Direct Data Entry (DDE) that is printed and signed off on. It is preferred that the signed PAS be either faxed to KEPRO to be attached or directly attached to the DDE version.

E. Inmates housed in a DCR facility with a diagnosis of dementia or Alzheimer's disease shall have a health care surrogate appointed for them who shall serve as the inmate's medical decision maker.

1. The process for having a health care surrogate appointed shall start at least ninety (90) days prior to the inmate's expected release date.

2. Appropriate medical and unit staff shall complete the Checklist for Surrogate Selection (**Attachment #1**) and submit to WVDHHR for assignment of a surrogate.

3. An inmate's family member may be appointed as the health care surrogate if willing.

III. A Level I review by a nurse reviewer will be completed within two (2) business days from the date the completed PAS is received. The submitter will be notified if additional information is needed for the Level I review. Timely submission of the information is critical, as the PAS will be deactivated if the additional information is not received within five (5) business days.

A. The Level I review determines whether the medical necessity eligibility requirements are met and issues approval for nursing home admission when appropriate. If medical necessity is not met, a denial letter will be issued and include information on appeal rights.

1. The criteria for medical necessity are listed in the policy manual at www.wvdhhr.gov/bms/.

a. An individual must have a minimum of five (5) deficits identified in order to qualify for Medicaid Nursing Facility benefit.

b. If there are less than five (5) deficits, the request is denied.

2. Determination of whether a Level II review is required will also be made.

B. Level II reviews are a federal requirement to assess the possible need for specialized services for intellectual and mental health issues (e.g. major mental disorder, intellectual/developmental disability, or related conditions).

1. Level II screenings are conducted by Psychological Consultation & Assessment Inc. (PC&A) on-site or by desk review.

2. Level II screenings extend the review process five (5) to seven (7) business days.

IV. Additional information is available by contacting KEPRO directly at 304-343-9663 or WVPAS@KEPRO.COM.

ATTACHMENT(S):

#1 Checklist for Surrogate Selection (4 pages)

APPROVED SIGNATURE: _____ 12-2-20

Betsy C. Jividen, Commissioner **Date**

Opt In ☐ **INITIAL box if surrogate agrees to have this form submitted to the WV *e-Directive* Registry, and released to treating health care providers. Complete information to RIGHT.**

REGISTRY FAX: 844-616-1415

Last Name/First/Middle _____
Address _____
City/State/Zip _____
Date of Birth (mm/dd/yyyy) _____/_____/_____
Last 4 SSN ___ ___ ___ ___ **Gender M**___ **F**___

Checklist for Surrogate Selection

(In accordance with the West Virginia Health Care Decisions Act)
W.V. Code - § 16-30-8

Patient's Name: _____

A. DETERMINATION IF HEALTH CARE DECISIONS ACT APPLICABLE

1. Is this patient an adult (over the age of 18), an emancipated minor, or a mature minor? Yes ____ No ____
If no, stop now. The Health Care Decisions Act of 2000 does not apply to selecting a surrogate to make decisions for children. An emancipated minor is a person over the age of 16 who has been declared emancipated by a judge or who is over the age of 16 and married. A mature minor is a person less than 18 years of age who has been determined by a qualified physician, a qualified psychologist, or an advanced nurse practitioner to have the capacity to make health care decisions.

2. Has the patient been declared "incapacitated"? Yes ____ No ____
If no, stop now. Make the decision with the patient. ("Incapacity" means the inability because of physical or mental impairment to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented, and to communicate that choice in an unambiguous manner.)

3. The determination of incapacity must be made by the attending physician, a qualified physician, a qualified psychologist, or an advanced nurse practitioner.

   Name of the physician _____ Date _____ Time _____

   a. Cause: _____

   b. Nature: _____

   c. Duration: _____

      i. Was the determination made regardless of age and disability? Yes ____ No ____
      If no, the patient must be reevaluated without a presumption of incapacity.

      ii. Does this patient have a court-appointed guardian with the authority to make health care decisions or Medical Power of Attorney (MPA)? Yes ____ No ___
      (Note that one physician, one licensed psychologist, or one advanced nurse practitioner who has personally examined the patient must document incapacity for the Medical Power of Attorney to be in effect.) If yes, the guardian or MPA representative is authorized to make health care decisions for the patient.

      Is the guardian or representative named in the MPA available and willing to serve? Yes ____ No ____

      If yes, stop and follow the directives of the guardian or representative in accordance with the patient's wishes, or if unknown, best interest. If the patient has a guardian or MPA representative, selection of a surrogate is not authorized by state law. If neither a guardian nor a MPA representative is available and willing to serve, proceed with surrogate selection.

Patient Name _____ Hospital # _____

B. SELECTION OF A SURROGATE

4. Identification of potential surrogates (If yes, enter name(s) in order of priority)
   Does the patient have:

   a. Spouse? Name: _____

   b. Any adult child of the patient? Names: _____

   c. Either parent of the patient? Names: _____

   d. Any adult sibling of the patient? Names: _____

   e. Any adult grandchild of the patient? Names: _____

   f. A close friend of the patient? Names: _____

   g. Such other persons or classes of persons including, but not limited to, such public agencies, public guardians, other public officials, public and private corporations, and other representatives as the department of health and human resources may from time to time designate?

   Names: _____

5. Who is best qualified to act as surrogate? Name: _____ Why?
   Does this person:
   a. Know the patient's wishes, including religious and moral beliefs? Yes ____ No ____
      If yes, basis:

   b. Know the patient's best interests? Yes ____ No ____
      The determination of knowing the patient's best interests was based on a discussion regarding (check if yes):
      1. The patient's medical condition ____
      2. Prognosis ____
      3. The dignity and uniqueness of the patient ____
      4. The possibility and extent of preserving the patient's life ____
      5. The possibility of preserving, improving or restoring the patient's functioning ____
      6. The possibility of relieving the patient's suffering ____
      7. The balance of the burdens to the benefits of the proposed treatment or intervention ____
      8. and, such other concerns and values as a reasonable individual in the patient's circumstances would wish to consider ____

   c. Have regular contact with patient? Yes ____ No ____
      If yes, enter nature and frequency of contact:

Patient Name _____ Hospital # _____

d. Demonstrate care and concern for the patient? Yes ____ No ____
If yes, enter the basis for this decision:

e. Visit the patient regularly during the illness? Yes ____ No ____

f. Engage in FACE-TO-FACE contact with the caregivers? Yes ____ No ____

g. Fully participate in the decision-making process? Yes ____ No ____

6. Is person available and willing to serve as surrogate? Yes ____ No ____
If no, select the best qualified person who is available and willing to serve and enter name

7. Is this person the highest person in the list from #4? Yes ____ No ____
If no, or if there are several persons at the same priority level, enter the reasons why the selected person is more qualified under factors 5 a-g above.

_____
_____
_____
_____

8. If conscious, the patient must be notified of the determination of incapacity and who the patients surrogate will be.

Date and time when notified: _____

Record patient response: _____

9. If the determination of incapacity is for a patient with psychiatric mental illness, mental retardation, or addiction, incapacity must be confirmed by another physician or licensed psychologist who has examined the patient. Is this necessary for this case? Yes ____ No ____

10. If yes, has this been done? Yes ____ No ____

If so, name of second health care professional declaring the patient incapacitated

_____

11. Were other potential surrogates notified of surrogate selection? Yes ____ No ____
If yes, enter names, date, time and by whom they were contacted.

Patient Name _____ Hospital # _____

Name	Date	Time	Contacted by

12. If a family member / close friend who was not selected disagrees with the surrogate chosen, tell him or her it is his / her responsibility to:
    a. Notify the attending physician in writing. ____ (Initial when done)
    b. Go to court to challenge the selection of the surrogate. ____ (Initial when done)

13. Did any potential surrogate object? Yes ____ No ____

    If yes, enter name and basis for objection: _____
    _____
    _____

14. Notify the person who objects that he / she has 72 hours to get a court order.

    Date _____ and time _____ notified.

I HAVE COMPLETED OR REVIEWED THIS FORM AND MADE THE DECISION TO APPOINT

_____ AS SURROGATE WHO

CAN BE REACHED AT PHONE NUMBER(S)

_____ (home) _____ (work) _____ (cell phone)

_____
Physician Signature / Date / Time

_____
Signature of person assisting the physician in completing this form (if any).

Acceptance of Surrogate Selection

I accept the appointment as surrogate for _____ and

understand I have the authority to make all medical decisions for _____.

_____
Signature of Surrogate