Community Preparation Plan

Nursing Facilities for Mental Health

Screener Training Manual

2017

Prepared by:
Kansas Department for Aging and Disability Services
Behavioral Health Services Commission

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Instructions for completion of Nursing Facility for Mental Health Community Preparation Plan Forms

Your primary source of information for completing the screening forms should be the individual being screened. Attempt to make this person comfortable by explaining the reason for the visit and the kinds of questions you will be asking. Offer to take short breaks if that is needed. A Consumer Facilitator may be able to help with this process. Other sources of information include: medical records, family members or guardians, Nursing Facility for Mental Health (NFMH) staff, community service providers, etc. Consult as many of these sources as possible and indicate the source(s) of the information when completing the form.

Screening forms should be typed or printed with black pen so that the assessment will be legible for Kansas Department for Aging and Disability Services/Behavioral Health (KDADS/BH) staff reviewers. Do not leave any spaces on the form blank; indicate a reason why any section is not answered completely. If you have questions about how to complete any section, ask your supervisor or you may call KDADS/BH at 785-296-3471 and ask for the Behavioral Health Services Adult Program Manager.

INSTRUCTIONS

SECTION I – SUMMARY SHEET:

This page is at the front of the screening document in the event that NFMH staff would like a copy of the findings for their records.

Fill in the individual's identifying information as requested in the box, at the top-left. This information should be available in the NFMH medical records, with the notable exception of the individual's preferred living arrangement. Preferred living arrangement should be stated in the person's own words, and then assigned one of the codes found at the bottom of page one. The "County of Responsibility" has been determined to be your Mental Health Center based on preliminary information from the NFMH. If after you interview the individual, you believe the "County of Responsibility" (COR) is not correct, make a note of the correct COR and notify your supervisor. Continue to complete your assessment. The definition for COR* is as follows:

*County of responsibility definition (from the Kansas Mental Health Reform Act – Procedures Manual)

"The county of Responsibility will be the one where the client lived independently or with family (in other than a boarding home, group home, NFMH, or other supervised living program) for six continuous months prior to the latest admission to a state hospital or other institution. (If an individual moves to a particular county for the purpose of receiving mental health services,

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and remains dependent upon those services, then that individual will remain the responsibility of his/her original county.)"

Comment sections are provided for each of the Screener and Facilitator. These may be used to note highlights, briefly summarize and/or elaborate on reasons for the recommendation checked in the appropriate box. In the Screener section there is a suggestion highlighted and in parentheses. "Future treatment planning" may be relative to discharge or to improving individual progress while remaining in the NFMH.

Be sure to sign and date on the lines available at the bottom of the comment section.
The bottom portion of the page is for KDADS to complete with the exception of the blank for Resident's Name. Fill this in on all pages of the screening form.

SECTION II – DIAGNOSIS AND TREATMENT HISTORY:

Primary Diagnosis - Make a check by each diagnosis that applies to this individual; include the DSM#.

*(**NOTE**: If after you interview this individual, you believe that the diagnosis of record may not be current or accurate, make a note that a new psychiatric evaluation is recommended.)

Other Diagnosis(es): List other significant diagnoses from the medical record. Include both mental and physical illness diagnoses.

Hospitalizations: This information should be available from the individual or in the medical record. Indicate the number of state psychiatric hospital stays and indicate which hospitals. Check whether any stays were more than 2 years. Indicate the number of psychiatric admissions to community hospitals and indicate where hospitalized. Note the dates of the most recent admission and indicate where this hospitalization occurred.

History of high-risk behaviors: Examples of behaviors that would fit this category include: fire setting, assault or physical aggression causing injury to others, self-inflicted injuries, wandering into traffic or getting lost due to an inability to attend to personal safety. Note the frequency and most recent date of occurrence and precipitating factors. If this behavior has occurred prior to the NFMH admission it would be important to note if the individual was receiving any mental health services at the time this behavior occurred.

Reason for referral to the nursing facility: Ask the individual to report why they were admitted to the nursing facility and search the NFMH admissions documents to find the reason for referral given in the medical record. Check the box most closely matching the reason given or mark the "Other" category and explain.

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SECTION III – SERVICES AND RESOURCES AVAILABLE:

The purpose of this section is to build a picture of the service resources, both formal and informal, used by the resident in the course of his or her treatment. Where possible, identify by name or by agency the resource used. If the resident is currently receiving services or support from an agency or individual, indicate this in the "Presently Available" column. In instances where a resource or support will be available to the resident in their community of choice, indicate this availability in the "Would be Available" column. Information gathered during this section should be kept in mind when completing the Strengths Assessment portion of the screening.

Check whether the individual has ever lived independently or semi-independently (ex: in their own apartment with family/roommate providing substantial assistance) in the past. Indicate how recently and for how long in order to help determine whether that experience was in the distant past prior to a long institutionalization or if it was recently enough to still be useful experience for them.

Check whether the individual has ever used community support services in the past and check the type of services used.

SECTION IV – ASSESSMENT OF FUNCTIONAL LIMITATIONS

Need for a level of care equal to that provided in an NFMH: This section is designed to determine whether the individual has one of five conditions that have most often been given as reasons for the need for nursing facility level of care. These five conditions indicate that the person has on-going symptoms or behaviors, despite adequate treatment, that cause severe limitations in the individual's ability to complete the majority of activities of daily living (ADL's) These categories would not be checked if the individual could manage their ADL's with substantial assistance.

While it may be likely that individuals with one or more of these conditions would be recommended for continued stay in a nursing facility, other options may also be considered. For example, programs that have the availability of 24-hour attendant care in the community may be able to serve these individuals outside of a nursing facility setting. Therefore, these conditions are indicators of the need for the most intensive level of service, but do not necessarily indicate where the service would be provided.

Check all that applies after careful consideration as to whether these conditions persist despite the presence of intensive service interventions.

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Assistance needed for activities of daily living: This section is designed to indicate how much assistance the individual needs or might need in order to perform each activity.

If you have a question as to the accuracy of the individual's own assessment of their ability, ask additional questions to gain a better understanding of how they have completed these tasks in the past. (Examples: Can you tell me what you like to fix yourself for dinner? Tell me how you did your grocery shopping. Can you tell me the medications that you are taking and how much you take at what times?) Individuals who become institutionalized may lose skills that they had prior to their institutionalization. Therefore, it becomes important to have an understanding of what skills the individual demonstrated prior to their admission to an institution.

NFMH staff may also express opinions about the individual's ability to complete these tasks and those may also be recorded. Ask NFMH staff if opportunities are provided for residents to plan and prepare their own meals, manage their own housekeeping, structure their own time, etc.

SECTION V – POTENTIAL FOR DISCHARGE TO THE COMMUNITY:

The assessment of strengths is considered a critical piece of the overall Screening procedure. This is the part of the interview that will most likely allow you to become aware of the individual's personal characteristics, interests and aspirations, as well as the environmental strengths (home, financial resources, friends, community connections, etc.) available to them. This information will afford you a much more complete picture of this individual than you would be able to determine from the other sections of the screening alone.

The Strengths Assessment has been incorporated into the screening document because an individual's strengths play a part in determining potential for discharge. The Facilitator may be able to play a significant role in this section and, depending on how the process has been defined, may complete this with the resident while the Screener reviews the chart and/or interviews collateral contacts.

Home community: This should be the community where the individual would choose to live. It may be the city they were admitted from or another city where they would now choose to go. If they state they want to remain in the NFMH please indicate that in this section and proceed to B.

Resources that would be necessary to assist the individual to live successfully in the community listed above:

Complete this section regardless of the individual's choice of living arrangement. Indicate the services and supports that would be needed to assist this individual to maintain themselves in

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any community living situation. If the individual has indicated that they wish to remain in the NFMH, complete this section based on the services available at the responsible mental health center.

Check all services/supports that would be needed on the left. Check whether these services/supports are currently identified in the home community listed in A (or responsible community) on the right. If there are supports needed that do not appear on the list, place a check in the "Other" category and list the specific services/supports needed.

SECTION VI – SCREENING FINDINGS

In this section you will indicate your findings as to whether the individual can be recommended for discharge to the community at this time. The recommendation should be based on a review of the individual's residential goal, their strengths and resources, the services and supports needed to adequately serve this individual, and whether the needed supports have been identified in the home/chosen community, as well as the capacity and flexibility of those supports. Keep in mind that services/supports should be individualized and often are developed "as needed" in strong community support programs. Therefore, it is not necessary to have in mind every potential support need at this point as long as you are familiar enough with the community's support system to know that flexible, creative responses can be developed as needs arise.

*NOTE: Homelessness or lack of financial resources should not be the determining factor for continued nursing facility placement. Case management services should be arranged to assist the individual to access temporary housing, benefits, and community resources for which they may be eligible.

SPECIAL INSTRUCTIONS: In cases where the assessment of the screening team indicates potential for discharge and the resident has a guardian who does not support this recommendation, please mark both "A" and the space labeled "Guardian does not support recommendation." List the concerns of the guardian in the "Additional Comments" section at the bottom of the page.

A. Recommended discharge to the community following development and implementation of an appropriate plan for community supports:

Check "A" if your findings indicate that the home/chosen community has sufficiently strong support services to respond to the needs identified for this individual and the person indicates that they desire to move to the community.

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B. Reason for continued stay in the NFMH

Check "B" if your findings indicated that this individual's service/support needs could not be met in the home/chosen community at this time. Place a check mark by the number indicating the reason. If there is a reason that does not fit in the three categories listed, check #3 "Other" and write an explanation in the additional comments section.

Additional Comments:

Use this space to record any additional information relevant to the findings for this individual. If you have other recommendations regarding this individual's future services (either in the NFMH or in the community) include those here. Examples include: recommendation for additional psychiatric evaluation, medication reviews, medical assessment, etc., notes regarding specific supports in the community that will be mobilized (or developed) for this individual, and recommendations regarding rehabilitation services that should be provided by the NFMH staff in order to assist the individual to prepare for a future discharge to the community.

SPMI CRITERIA:

Check whether the individual would meet criteria for having a "severe and persistent mental illness". If after completing the screening you have questions regarding this individual's SPMI status, indicate that in the space provided for explanation.

SIGNATURES:

Complete this section and forward all screening materials Screens for Continued Stay to the Qualified Mental Health Professional (QMHP) designated in your agency to review Screens for Continued Stay (SCS). When all necessary signatures have been obtained, the completed screen and medication information should be emailed to the email address included on the form. Forms will not be accepted via fax or regular mail.

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Screens for Continued Stay (SCS)
Policy and Procedure Manual

SECTION I: INTRODUCTION

The State of Kansas requires an annual review of the service needs of individuals with severe and persistent mental illness (SPMI) residing in Nursing Facilities for Mental Health (NFsMH), referred to as Screens for Continued Stay (SCS). This requirement applies only to individuals whose care is funded through the Kansas Department for Aging and Disability Services (KDADS). The regulation is found in K.A.R. 30-70-7(d):

"Each individual admitted to a nursing facility for mental health shall be evaluated at least annually upon the anniversary of admission, and at any other time there may have been a significant change in the resident's mental condition. This evaluation shall be made under supervision of a qualified mental health professional employed by a participating community mental health center, as defined in K.S.A. 59-2946 and amendments thereto, using the screening tool that may be designated by the Secretary, to determine whether it is appropriate for that individual to remain in a nursing facility for mental health. Any state-funded individual for whom it is determined that remaining in the facility is inappropriate may be required to have prepared a plan for that individual's transfer to appropriate care."

Screening Team Members:

CMHC-NFMH Liaisons: These are Community Mental Health Center (CMHC) staff members designated to perform coordination functions between the NFMH and the CMHC for NFMH residents.

NFMH-SCS Contact Person: These are the individuals designated by each NFMH to assist in the coordination of the SCS process.

SCS Screener: This is the CMHC staff member who assesses the NFMH resident using the SCS form. (SCS Screener will use Training Module-Power Point developed by KDADS)

Screening Facilitators: These individual consumers who are paid to provide pear support and knowledge based upon life experience and their own recovery.

The goals for this Initiative include:

- Ensuring that individuals receiving state supported mental health services through NFsMH are being served in the most integrated community setting appropriate to their needs. As noted in a letter issued to all of the Governors by the U.S. Department of Health and Human Services following the issuance of the U.S. Supreme Court's 1999 Olmstead Decision, "no person should have to live in a nursing home or other institution

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if he or she can live in his or her community" and further "unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act".

- Ensuring that NFMH residents are aware of the options they have which may include living in community settings with the support of community-based services to meet their specific needs and receiving assistance in determining what their specific support needs might encompass.
- Collecting data about the service and mental health needs of NFMH residents, contributing to additional program and policy development.
- Assuring that State general funds are being directed toward the most effective and appropriate treatment settings based upon medical necessity.

SECTION II: OVERVIEW OF SCS PROCESS

Designation of NFMH/CMHC Liaisons:

CMHC and NFsMH will each designate staff members responsible for implementation and coordination of the Screens for Continued Stay with all parties involved.

Individuals to be screened:

All individuals residing in NFsMH are required to have an annual Screen for Continued Stay. Some individuals in NFsMH may have a payer source other than Medicaid. KDADS can only pay for screens for Medicaid Individuals, however, due to the payment process in use. CMHC and KDADS can make recommendations about other resources for these individuals; however, they can continue to reside in the NFMH if they choose.

Note: A Screen for Continued Stay need not occur to discharge or to begin working toward discharge to a community setting. Screens for Continued Stay should be implemented with individuals who have been in residence longer than six months.

Dissemination of Data:

KDADS will provide information to each CMHC regarding the residents from their County of Responsibility (COR) residing in NFMHs, based on information provided by the NFMHs.

Screener Training and Registration:

Screens for Continued Stay will be conducted by CMHC staff that has been trained by a currently registered screener using the PowerPoint module developed by KDADS. After being trained, the individual's supervisor can submit the individual's contact information (Name, Center, mailing address, email address) and training date to KDADS and a screener number will be provided.

Screening Facilitators:

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Screeners will be assisted by consumers living in the community, known as Facilitators, whenever possible. These individuals will be trained by a currently registered screener using the PowerPoint module developed by KDADS and will provide education about community living and peer support to the resident being screened throughout the screening process.

Screening Findings:

After completion of the assessment, the screener and facilitator will each provide recommendations to KDADS. These recommendations will address either the resident's transition into the community or the reasons for a continued stay in the facility. For individuals who will be continuing to reside in the facility, screeners and facilitators may make recommendations including the need for additional rehabilitation services and supports in preparation for a future move to a more independent living situation.

KDADS Review of Findings:

After receiving the completed screen, KDADS will review the screen for the quality and completeness of the information, formalize the recommendation, and communicate the screening findings to the resident, their guardian (if applicable), the NFMH, and the CMHC.

Discharge Process:

When an individual in a NFMH has been recommended for community integration through the SCS process, the NFMH is eligible for payment via state general funds for an additional 120 days.

If discharge is recommended, the CMHC in the community where the person chooses to live will assign a case manager, develop a discharge plan, and begin working with the resident to establish the benefits and supports needed for his/her move to the community. In situations where a resident wishes to move to the catchment area of a CMHC other than the one designated to have responsibility, discharge planning and division of responsibilities for implementing the plan will be arranged, in concert, by both CMHCs.

SECTION III: ROLES AND RESPONSIBILITIES

CMHC RESPONSIBILITIES

Each CMHC will assign a CMHC-NFMH Liaison, who will serve as a point of contact with KDADS, act as a liaison with the NFMHs and other CMHCs, and oversee coordination of services for those being discharged.

Screener Responsibilities: The roles and responsibilities of a screener include the scheduling and completion of a "Screen for Continued Stay", as well as recommendations and referrals to appropriate services. These assessments will be conducted in a culturally-sensitive

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manner with provisions for assessments of non-English speaking individuals. The specific tasks are described below:

The SCS will include completion of the "Screen for Continued Stay." This includes completion of a "Consumer Strengths Assessment" which is incorporated into the SCS document. Screeners and facilitators will complete the assessment documents based on information obtained from a variety of sources, including: a face-to-face interview with the individual being screened, review of medical records, discussion with NFMH staff, and discussion with family members, guardians, or other individuals as requested by the resident.

Following completion of the assessment, the screener and facilitator will each make a recommendation for either discharge to the community upon development and implementation of an appropriate plan for community supports, or continued stay in the NFMH, identifying the reason that community discharge is not possible at this time. If discharge is recommended, and once needed services have been determined, the screener will communicate with the Community Support Services (CSS) program where the resident desires to live (either their own CSS program or another if the person chooses to live outside their county of responsibility). A determination will then be made as to whether the supports necessary for discharge to the community are available.

The screener and facilitator will be available, if necessary , for participating in the appeals process. (See Section V for more information.)

CMHC Steps for Conducting SCSs:

1. The CMHC will review the list of NFMH residents in their catchment area.
2. If the screener determines that the COR is incorrect, the CMHC should complete a SCS with each individual and follow the instructions in the COR Section of this manual. CMHCs may request courtesy screens if individuals identified in their COR reside in an NFMH located a long distance from the CMHC catchment area.
3. A screening team consisting of the CMHC-MFMH Liaison, screener, and facilitator will meet to determine how they will work together to complete the SCSs.
4. The NFMH will be contacted according to the screening team's plan to schedule times to complete the SCSs.
5. The screener and facilitator will meet with the residents, interview staff, review medical records, and collect other information necessary to complete the SCS.
6. The screening document will be reviewed and signed by a QMHP from the responsible CMHC.
7. Once the SCS is completed, the documents will be emailed to the BHS Senior Administrative Assistant. The appropriate email address is included on the form. Completed forms will not be accepted via fax or mail and must be submitted in Word (doc/docx) format. The signature page, Strength's Assessment, and front page with

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facilitator's comment/signature may be scanned and submitted as an additional file, but the screening form itself must be submitted as a Word document.

8. When the criteria set forth in the current edition of the instruction manual is met, CMHCs will receive $255 reimbursement per screen. The facilitator will receive $50 reimbursement per screen. The CMHC will bill for the full amount (including facilitator's payment if applicable) to KMAP using the T2011 code, then provide the facilitator their payment from that total amount. **(If a facilitator is used, the CMHC bills for $305 total. If there is no facilitator utilized, the CMHC bills for only $255 total.)**

CMHC Post Screening Responsibilities:

Once the CMHC is notified of KDADS approval for the recommendations received on the SCS form, the CMHC is then responsible for follow-up activities based on these recommendations. There are several potential outcomes after an NFMH resident has been screened. These include:

A. Recommended discharge to the community following development and implementation of an appropriate plan for community supports:

A timeline of 120 days will be allowed for the planning and coordination of services and supports for a person screened with a disposition of community integration, after which State General Funds (SGF) to the NFMH will be discontinued for that individual. The 120 day time line begins on the date KDADS/BH approves the SCS. During this time period, the CMHC will work with the individual/guardian, family, NFMH staff and any others identified by the resident to develop the services and supports the person will require to move to the community. Individuals in NFMHs may require additional services and supports to assist in transitioning to the community. Community Psychiatric Support and Treatment (CPST) and Targeted Case Management (TCM) can be utilized to facilitate identification of needed services and supports a person will require to live in the community. CPST and TCM are billable services with a procedure code of H0036 HB for CPST and a procedure code of T1017 for TCM. 120 hours of Attendant Care can also be provided per beneficiary per year from the approval date of the annual SCS screen for residents of a NFMH when the following conditions are met: 1) a SCS must be completed within the last year with a recommended disposition of discharge, 2) a treatment plan has been developed by the CMHC with a goal of "community integration", and 3) Attendant Care service is provided in the intended discharge community. Attendant Care service is billable by CMHCs to Medicaid with procedure code T1019.

Occasionally, due to a medical emergency or other unforeseen circumstance, 120 days may be insufficient to accomplish community living. In the event a person is unable to move out of the NFMH in the 120 day period, an extension may be requested. The CMHC will notify KDADS/BH in writing, at least 30 days prior to discharge or at the earliest possible date, in the

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event of an emergency. The CMHC will submit written documentation to support the need for extension of the 120 day time limit. KDADS/BH will complete a case review and determine if the extension is warranted. If an extension is approved, a new timeline will be established to allow for the CMHC to continue coordinated planning and work with the individual toward the goal of community living.

B. Recommended continued stay in the NFMH:

If after thorough review of the findings and exploration of possible options, it is determined the individual's service/support needs could not be met in the home/chosen community at this time. It is expected that the CMHC continue to monitor the individual and to develop service/support to facilitate transition of the individual at the earliest possible opportunity. Persons residing in NFsMH must meet the need for the level of care provided in the facility. A shortened version of the annual screen for continued stay is available for screening persons who have severe or terminal health condition. Example: Individual is on Hospice.

In the additional comments section of the SCS form, any pertinent information or recommendations that will be helpful in assisting the resident with their recovery should be noted. Examples included:

- Rehabilitation services that should be provided in order to assist the individual in preparing for a future discharge to the community.
- Additional physical or mental health assessments recommended including medication reviews, e.g.
- Education and information on recovery and community living.
- Continued or enhanced community contacts, such as CROs, family members, and other sources of support.

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NFMH RESPONSIBILITIES

- Each NFMH will assign a liaison to work with the CMHC liaison to oversee coordination of services for individuals within NFsMH. Responsibilities of the NFMH liaison include: Working in partnership with the CMHC liaison to arrange the screening. NFMH liaisons will ensure that the SCS screener has access to all necessary information such as medical records, collateral contacts, and any additional resources that would assist in the screening process;
- Work collaboratively with the CMHCs to develop transition plans for those individuals who can and want to move into the community;
- Develop and/or revise care plans, taking into consideration the findings and recommendations from the Screen for Continued Stay form, for those individuals identified as needing the continued level of service provided in the NFMH.
- A general contact list will be provided; however the names may change do to staff turnover.

SCREENING FACILITATOR RESPONSIBILITIES

The list of Screening Facilitators will be provided to each CMHC by KDADS upon request, with the understanding that former facilitators may still be listed, as KDADS is not notified when someone chooses to no longer participate. The list is only as accurate as the information the Centers provide. From this list, the CMHC will contact the facilitators available in their area to assist with the SCS process. Facilitators will have completed required training and been assigned a number, and will be prepared to provide a friendly, caring, supportive community peer resource to those individuals currently residing in NFMHs. Their assistance will serve to support as smooth and comfortable a screening process as possible for the participants. As facilitators may not be available in all areas, the presence of a facilitator is not required for the completion of the SCS; however, facilitators are highly recommended to participate in this process. Responsibilities include:

- Completion of the Strengths Assessment portion and contribution to the recommendations of the SCS Facilitate the development of one-to-one relationships between consumers living in the community within a given individual's county of responsibility and those individuals currently residing in an NFMH. Facilitators will attempt to foster hope and encouragement as well as identify available resources for those residents who wish to move from an NFMH back into the community. This relationship may also help residents identify ways in which the NFMH experience contributes to their recovery process.
- Accompany CMHC staff to NFMHs for participation in the SCS process.
- Provide peer support throughout the screening process for those consumers scheduled to be screened.

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- Provide information and resources related to community living not only to residents but also to guardians (as applicable), the NFMH staff, and/or the CMHC screeners.

*Note-The strengths assessment must still be completed by the screener if a facilitator is not available.

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KDADS RESPONSIBILITIES

KDADS Behavioral Health Services is responsible for establishing policies and procedures and overseeing the SCS process. Specific responsibilities include:

- Provision of policy and procedure instructions, development of screening tools, development and provision of appropriate training for all parties involved in conducting the screens, and assignment of certification numbers.
- Provision of information identifying NFMH residents to be screened to the appropriate CMHC staff. New resident and other lists identifying the NFMH population will be made available via email throughout the year.
- Review completed SCS documents and notify the resident, CMHC, NFMH, and guardian (if applicable) of the SCS findings. A copy of the cover sheet of the SCS document will be provided to the CMHC and NFMH.
- Conduct periodic meetings for participants to ensure communication and coordination with the SCS tasks.
- Track screening outcomes and other data necessary for future state policy development.

SECTION IV: COUNTY OF RESPONSIBILITY

For purposes of the SCS, the concept of "county of responsibility" has been defined as follows: The county of responsibility is the county from which the consumer originally came or the county where the consumer lived independently or with family (in other than a group home, boarding home, NFMH, or other supervised living facility) for at least six continuous months prior to the latest admission to a state hospital or other institution.

The CMHC serving the resident's assigned COR will be responsible for conducting the SCS evaluation and for follow-up activities consistent with the screening findings.

NOTE: If the Screener determines during the screening process that the preliminary COR is incorrect, they should continue to complete the screening evaluation and notify their CMHC-NFMH Liaison of the need to change the COR. In completing the SCS documents, the determination of what community supports identified in the individual's home community or desired community (if they choose to relocate when they are discharged). The Screener would need to contact the CMHC-NFMH Liaison in the home or desired community in order to identify the available resources and complete the screening documents. The need for a change in the COR should be indicated in the "Additional Comments" section of the SCS form. The CMHC-NFMH Liaison from the original CMHC should contact the CMHC-NFMH Liaison for the CMHC serving the corrected COR determined by the Screener in order to arrange for the change in the assigned COR. KDADS should then be notified of the COR change. If an agreement regarding

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the correct COR cannot be reached, the affected CMHCs should contact KDADS Behavioral Health Commission for final determination on the COR assignment.

For NFMH residents who choose to be discharged to a community outside the catchment area of the CMHC serving their COR, the CMHC serving their new home community will be responsible for assigning a case manager, developing a discharge plan and implementing the necessary community support services. The assignment of COR for purpose of tracking usage of State Hospital bed days will remain with the original CMHC until the former NFMH resident has lived independently in the new catchment area for a period of six months. (This is the same procedure as in place for persons discharged from the state psychiatric hospitals.)

SECTION V: APPEAL PROCESS

Consistent with KDADS policy, individuals screened through the SCS evaluation process have the right to appeal the screening findings. Each individual screened will be notified at the time of the SCS determination that she/he or their court appointed legal guardian has the right to appeal the decision. The information in the letter gives direction that the appeal must be in writing and submitted within thirty (30) days of the determination. The request for an appeal hearing is to be sent to:

The Office of Administrative Hearings
610 SW Tenth Ave, 2nd Floor
Topeka, KS 66612-1616

The screener who completed the SCS form will need to attend the hearing and be prepared to testify if requested. (This can be arranged through a tele-conference call.) If an appeal hearing is held, the hearing officer will issue the final decision in writing to all parties involved.

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APPENDIX

List of contacts for KDADS, KDHE, KAPS, Long-Term Care Ombudsperson, etc.
SCS Form - blank
SCS Form - completed example)
Screener Qualifications
Facilitator Job Description
NFMH Contact List

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List of Useful Contacts

GENERAL QUESTIONS OR CONCERNS

Behavioral Health Services Main Number: **785-296-3471**

REPORT CHILD OR ADULT ABUSE OR NEGLECT

Abuse Hotline: **800-922-5330**

QUESTIONS OR CONCERNS ABOUT NURSING FACILITIES FOR MENTAL HEALTH

Kansas Department for Aging and Disability Services Survey and Certification Commission: **800-842-0078**

APPEAL A DECISION OR REQUEST A FAIR HEARING

1020 S Kansas Avenue
Topeka, Kansas 66612-1311
785-296-2433

INFORMATION ABOUT APPLYING FOR GUARDIANSHIP IN KANSAS

The Kansas Guardianship Program: **800-672-0086**

LONG-TERM CARE OMBUDSMEN'S OFFICE

900 SW Jackson, Suite 1041
Topeka, Kansas 66612
(785) 296-3017
Toll free: (877) 662-8362

DISABILITY RIGHTS CENTER OF KANSAS

214 SW 6th Ave., Ste 100
Topeka, KS 66603
Topeka voice: (785) 273-9661
Toll free: (877) 776-1541

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KDADS Screens for Continued Stay (SCS) for NFMH Residents

Date of Resident's Last Screen for Continued Stay: _____

*(**Do not use date of last PASRR or Resident Review**)*

SECTION I SUMMARY SHEET

Date of Screen: _____
Resident Name: _____
Maiden Name (if applicable): _____
Birthdate: _____
Gender: _____
Social Security Number: _____
Medicaid ID Number: _____
Date of Admission: _____
Responsible CMHC: _____
Resident NFMH: [Choose one]
Screener Name: _____
Screener Number: _____
Screener CMHC: _____
Facilitator Name: _____
Facilitator Number: _____

Select Resident's Preferred Living Arrangement:
<Choose from these options>

SCREENER DETERMINATION

Recommended Disposition: Continued Stay: ☐ Discharge: ☐

Courtesy Screen: ☐

Screener Comment/Current S.M.A.R.T goals

kjkhb — **Signature & Credentials**

03/17/2017 — **Date**

FACILITATOR DETERMINATION

Facilitator Comment:

Recommended Disposition: Continued Stay: ☐ Discharge: ☐

☐ **Facilitator unavailable at this time.**
Reason: _____

_____ **Signature & Credentials**

_____ **Date**

KDADS DETERMINATION:

Approved ☐ Not Approved ☐ Conditional ☐ (See Comments)

_____ **Signature & Credentials**

_____ **Date**

Office Use Only:

Approved for payment	Date	Initials

Route to: CMHC, NFMH, KDADS-BHS

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SECTION II DIAGNOSIS AND TREATMENT HISTORY

Please select the client's DSM-5 principle/tier 1 diagnoses from the following list

☐	Schizophrenia	(F20.9)
☐	Schizoaffective Disorder, Bipolar Type	(F25.0)
☐	Schizoaffective Disorder, Depressive Type	(F25.1)
☐	Bipolar Disorders that are Severe, and/or with Psychotic Features	(F31.2) (F31.5)
☐	Major Depressive Disorder, Recurrent, Severe with Psychotic Features	(F33.3)
☐	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	(F28)

Please indicate any additional diagnoses the client may have: Code:

Hospitalizations:

Number of hospitalizations in:	
State Hospitals:	
Community Hospitals:	
Where Hospitalized:	

Any Stays of 2 years or more?
☐ Yes ☐ No

History of high-risk behaviors:

Please indicate whether the resident displays any of the included high-risk behaviors listed in the available dropdown boxes. Include frequency of behavior and the date of the most recent occurrence of such.

Behavior	Frequency	Most Recent Occurrence
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		

Reason(s) for referral to the nursing facility *(as stated on PASRR form/letter):*

(check all that apply)

- ☐ Needed medication management assistance
- ☐ Needed assistance with Activities of Daily Living and Instrumental Activities of Daily Living
- ☐ Had medical need or needs for special treatments requiring 24-hour nursing care
- ☐ Displayed behaviors not tolerated by the community
- ☐ Exhibited dangerous behaviors
- ☐ Other:

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SECTION III SERVICES AND RESOURCES AVAILABLE

The purpose of this section is to build a picture of the service resources, both formal and informal, used by the resident in the course of his or her treatment. Where possible, identify by name or by agency the resource used. If the resident is currently receiving services or support from an agency or individual, indicate this in the "Presently Available" column. In instances where a resource or support will be available to the resident in their community of choice, indicate this availability in the "Would Be Available" column. Information gathered during this section should be kept in mind when completing the Strengths Assessment portion of the screening.

Has lived independently or semi-independently in the past? ☐ Yes ☐ No	
How recently?	For how long?
Has used community support services (CSS) in past? ☐ Yes ☐ No	

CMHC RESOURCES	Has Used In Past	Presently Available	Would be available
Case Manager	☐	☐	☐
Psychologist	☐	☐	☐
Therapist	☐	☐	☐
Attendant Care	☐	☐	☐
Crisis Stabilization Services	☐	☐	☐
Medication Assistance	☐	☐	☐
Psychosocial	☐	☐	☐
Psychiatrist	☐	☐	☐
Housing Services	☐	☐	☐
Supported Employment	☐	☐	☐
Supported Education	☐	☐	☐
Other?	☐	☐	☐

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FAMILY & FRIENDS **Please identify**	**Has Used In Past**	**Presently Available**	**Would be Available**
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

OTHER COMMUNITY RESOURCES	**Has Used In Past**	**Presently Available**	**Would be Available**
Consumer-Run Organizations	☐	☐	☐
Primary Care Physician	☐	☐	☐
Guardian (if applicable) **(If a guardian is indicated, you must include all contact information)**	Name: Address: Phone #:	☐	☐
Payee (if applicable) **(If a guardian is indicated, you must include all contact information))**	Name: Address: Phone #:	☐	☐
Independent Living Center	☐	☐	☐
Respite Care	☐	☐	☐
In-home skills teaching	☐	☐	☐
Home Health Care	☐	☐	☐
Community Psychologist/ Psychiatrist	☐	☐	☐

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SECTION IV ASSESSMENT OF FUNCTIONAL LIMITATIONS

A. Need for a level of care equal to that provided in an NFMH:

Presence of one or more of the following conditions, despite adequate treatment including a reliable medication regimen, would indicate the need for a level of service equaling the intensity of nursing facility care. These conditions are indicators of the intensity of service needed, not necessarily where the service would be provided.

Note: These categories indicate severe levels of impairment continuing despite intensive treatment. They should not be checked unless there are on-going behaviors causing an inability to complete the majority of activities of daily living even with substantial assistance.

(Check all that apply)

☐	**(1)** Presence of a severe cognitive impairment, or combination of cognitive and physical impairments, which render the individual unable to provide even minimally for their basic health and safety needs (e.g. wandering from their living space with no regard for personal safety, inability to feed themselves or clothe themselves, inability to manage toileting, bathing, etc. either independently or with prompting.) Note: This refers to the lack of the basic skill to accomplish the task, not to the appropriateness of dress, meal choices, or personal hygiene.)
☐	**(2)** Presence of severe psychiatric symptoms which cause extreme withdrawal and social isolation, in combination with a thought disorder which prevents independent or semi-independent functioning for the majority of instrumental activities of daily living such as: shopping, meal preparation, laundry, basic housekeeping, money management, taking medications.
☐	**(3)** Presence of severe psychiatric symptoms which cause frequent socially inappropriate behaviors that are not easily tolerated in the community (e.g. screaming, minor self-abusive acts, inappropriate sexual behavior, verbal harassment of others), or that cause a long-standing pattern of dangerous behaviors (e.g. serious self-harm, violence toward others, fire-setting, etc.) that occur unpredictably and despite on-going aggressive treatment. in combination with a thought disorder which prevents independent or semi-independent functioning for the majority of instrumental activities of daily living such as: shopping, meal preparation, laundry, basic housekeeping, money management, taking medications. List date and nature of most recent episode: _____
☐	**(4)** Presence of an on-going alcohol or drug addiction in combination with severe psychiatric symptoms causing a long-standing pattern of dangerous behaviors (e.g. serious self-harm or violence toward others) that occur unpredictably and despite current treatment efforts. List date and nature of most recent episode: _____
☐	**(5)** Medical issues requiring nursing assistance and monitoring. Describe: _____

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Assistance needed for activities of daily living:

Check the box that best describes the amount of assistance the resident feels they need in the following skill areas. If the NFMH staff indicates a different opinion, space has been provided to indicate both perspectives.

	Resident Assessment	Screener Assessment
1. Taking Medications	<Choose an item>	<Choose an item>
2. Managing health care	<Choose an item>	<Choose an item>
3. Money management	<Choose an item>	<Choose an item>
4. Grocery shopping	<Choose an item>	<Choose an item>
5. Meal preparation & preparation	<Choose an item>	<Choose an item>
6. Laundry	<Choose an item>	<Choose an item>
7. Hygiene	<Choose an item>	<Choose an item>
8. Housekeeping	<Choose an item>	<Choose an item>
9. Structuring free time:		
Weekdays	<Choose an item>	<Choose an item>
Evenings	<Choose an item>	<Choose an item>
Weekends	<Choose an item>	<Choose an item>

Additional comments regarding skills: _____

SECTION V POTENTIAL FOR DISCHARGE TO THE COMMUNITY

The assessment of the level of care needs for an NFMH resident must include a comprehensive review of the individual's strengths and goals, as well as, their service, support, and financial needs, and the community's capacity to respond to those needs, prior to the determination that continued nursing facility placement is the best option. Therefore, a "Consumer Strengths Assessment," similar to that used in Community Support Services programs across Kansas, has been included as part of the screening tool. It is strongly recommended that the screening facilitator complete this section of the Screen for Continued Stay. Continuing NFMH care should only be recommended for individuals whose needs cannot be met in the community. Therefore, a review of the community's capacity to provide needed support is a critical piece of the assessment. Both formal and informal sources of support should be considered.

Note: If the screener and facilitator are unfamiliar with services in the resident's home community (or community of choice), the mental health center in that community should be contacted for assistance in identifying the needed resources.

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Strengths Assessment

Consumer's Name *Facilitator's Name*

Current Status: What is going on today? What's available now?	**Individual's Desires, Aspirations:** What do I want?	**Resources, Personal Social:** What have I used in the past?
	(Life Domain) **Daily Living Situation**	
	Financial/Insurance	
	Vocational/Educational	
	Social Supports	

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	Health	
	Leisure/Recreational Supports	
	Spirituality	

What are my priorities?

1. *3.*

2. *4.*

Consumer Comments:	Facilitator's Comments:

Consumer's Signature **Date** **Facilitator's Signature** **Date**

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A. Home Community (List city the resident would choose to return to or move to if he/she were discharged from the NFMH): _____

B. Resources that would be necessary to assist the individual to live successfully in the community listed above: (If this community is outside of the Screener's catchment area, list name and phone number of person contacted to assist in identification of needed services)

Name: _____ Phone Number: _____

Check all resources that the resident will need in the community. Then, indicate if the resource is an existing resource, or if it is a currently undeveloped one.

Resource Needed		Existing Resource	Resource Not Available/ Developed At This Time
	General Assistance:		
☐	1. Affordable housing or housing subsidy	☐	☐
☐	2. Attendant care services	☐	☐
☐	3. Case management services to assist in goal planning, mobilizing community supports, problem solving, assisting the individual to learn to use available resources, and crisis intervention	☐	☐
☐	4. Community recreational activities	☐	☐
☐	5. Consumer-Run Drop-In Center or social support activities	☐	☐
☐	6. Crisis Stabilization/Respite Program available as needed	☐	☐
☐	7. Housekeeping services	☐	☐
☐	8. In-home medication services (med. drops, prompts to take meds, etc.)	☐	☐
☐	9. Meals-on-Wheels or other nutrition assistance	☐	☐
☐	10. Money management assistance or Conservator or Payee	☐	☐
☐	11. Natural supports, such as family, roommates, friends, church, etc.	☐	☐
☐	12. Psychiatric services and medication management	☐	☐
☐	13. Psychosocial rehabilitation including in-home skills teaching	☐	☐
☐	14. Transportation assistance	☐	☐
☐	15. Vocational assistance	☐	☐
	Medical Assistance:		
☐	16. Assistive devices	☐	☐
☐	17. Personal care services	☐	☐
☐	18. Visiting nurses	☐	☐
☐	19. Friends/Visitors/senior companions or similar program	☐	☐
	Substance Abuse Services:		
☐	20. AA/NA programs appropriate for persons with dual diagnosis	☐	☐
☐	21. Community in-patient chemical dependency treatment	☐	☐
☐	22. Community out-patient chemical dependency treatment	☐	☐
	Other services (list)		
☐	23. _____	☐	☐
☐	24. _____	☐	☐

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SECTION VI SCREENING FINDINGS

Note: *Homelessness or lack of financial resources should not be the determining factor for continued nursing facility placement. Case management services should be arranged to assist the individual to access temporary housing, benefits, and community resources for which they may be eligible.*

Check A or B.

In cases where the resident's guardian does not support the screening team's recommendation, please list their concerns in the comments section below the "Screener spoke with the guardian" checkbox.

☐ **A. Recommend discharge to the community following development and implementation of an appropriate plan for community supports**

☐ **B. Reasons for continued stay in NFMH** (Indicate reasons below. Check only one.)

☐ **(1)** At this time the resident's level of disability due to mental illness appears to be so severe that even the most intensive community services would be insufficient (refer to Section IV)

☐ **(2)** This person could be served in the community with development of resources listed in the comments section, but at this time, these resources have not been developed.

☐ **(3)** Medical issues necessitate continued stay (please give further detail in the comment section)

☐ **(4)** Other (List below)

Recommendations for additional Community Preparation Skills: _____

Additional Comments: _____

☐ *Screener spoke to the NFMH Administrator or designee at the facility regarding this recommendation. Comments* _____

☐ *Screener spoke to the guardian regarding this recommendation.*

☐ *Guardian agrees with the screener's recommendation.*

Comments _____

SPMI Criteria: Note whether the individual screened meets criteria for having a "severe and persistent mental illness." **YES** ☐ **NO** ☐

If the individual does not meet SPMI criteria, or if additional diagnostic assessment is needed in order to make the determination, or if you question the current diagnosis of record, please explain: _____

SIGNATURES:

_____ _____

Signature and Credentials of Screener Date

_____ _____

Community Mental Health Center Screener Number

Phone number: Work: _____ Cell: _____ Email Address: _____

_____ _____

Signature of Qualified Mental Health Professional (QMHP) Date

Phone number Work: _____ Cell: _____ Email Address _____

Within two (2) working days of completing the screen, please email a copy of this form, including the completed Consumer Strengths Assessment, to diana.marsh@ks.gov. If you have any questions about this form, please contact Chris Bush at Chris.Bush@ks.gov or Diana Marsh at Diana.Marsh@ks.gov.

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EXAMPLE **Date of Resident's Last Screen for Continued Stay:** 02/03/2016
*(**Do not use date of last PASRR or Resident Review**)*

SECTION I SUMMARY SHEET

Date of Screen: 02/07/2017
Resident Name: John/Jane Doe
Maiden Name (if applicable): _____
Birthdate: 01/01/1970
Gender: male/female
Social Security Number: 123-45-6789
Medicaid ID Number: 000000009800
Date of Admission: 04/08/2011
Responsible CMHC: **COMCARE**
Resident NFMH: Medicalodge of Paola
Screener Name: Tom Baker
Screener Number: 00Z04ABCS
Screener CMHC: Comcare
Facilitator Name: Peter Capaldi
Facilitator Number: 00Z12ABCF

Select Resident's Preferred Living Arrangement:
D) Live in NF/NFMH

SCREENER DETERMINATION

Recommended Disposition: Continued Stay: ☒ Discharge: ☐
Courtesy Screen: ☐

Screener Comment/Current S.M.A.R.T goals

The Screener will add any note, goals, or observations relative to their determination here, such as: Jane/John Doe mood initially was friendly as he/she was looking forward to visit with us, but his/her mood quickly changed & became agitated with us. He/She cursed at screener & abruptly ended the interview. Nurses & others (who) observed that Jane/John Doe continues to have poor boundaries, easily agitated, demanding & yelling if his/her needs are not met; non-compliant with meds at times, socially inappropriate, has verbal & physical altercations. Most recent concern this past year is his/her interacting with peers that don't allow him/her to be in control of watching television causing him/her to have outburst and hiding the t.v. controller and unplugging the t.v. He/She continues to exhibits symptoms of paranoia, anxiety, suspicion, hallucinations & delusions at times. His/Her mood is labile & had multiple incidents of physical altercations within the past 2 months when discussion came up about other possible living arrangements.

Tom Baker, ABC, DE — **Signature & Credentials**
02/07/2017 — **Date**

FACILITATOR DETERMINATION

Facilitator Comment:
If Applicaple….Faciliator will enter a statement justifying why they recommend reason for continued Stay…example…John/Jane Doe expressed they was not ready to leave/individual is not ready, etc

Peter Capaldi — **Signature & Credentials**
02/07/2017 — **Date**

Recommended Disposition: Continued Stay: ☒ Discharge: ☐

☐ **Facilitator unavailable at this time.**
Reason: if no facilitator is available, please be sure to click the box above and provide an explanation here.

KDADS DETERMINATION:

(Once the form has been reviewed, KDADS will provide their comments and determination here. please do not enter anything into this section.

Approved ☐ Conditional ☐
Not Approved ☐ (See Comments)

_____ **Signature & Credentials**
_____ **Date**

Office Use Only:

Approved for payment	Date	Initials

Route to: CMHC, NFMH, KDADS-BHS

SECTION II DIAGNOSIS AND TREATMENT HISTORY

Please select the client's DSM-5 principle/tier 1 diagnoses from the following list

☒	Schizophrenia	(F20.9)
☐	Schizoaffective Disorder, Bipolar Type	(F25.0)
☐	Schizoaffective Disorder, Depressive Type	(F25.1)
☐	Bipolar Disorders that are Severe, and/or with Psychotic Features	(F31.2) (F31.5)
☐	Major Depressive Disorder, Recurrent, Severe with Psychotic Features	(F33.3)
☐	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder	(F28)

Please indicate any additional diagnoses the client may have:

	Code:
Gastro-Esophageal Reflux disw/o Esophagitis,	K21.9
Type 2 Diabetes Mellitus w/o complication,	E11.9
Obesity, Unspe,	E66.9
Insomnia, Unspecified	G47.00
Essential (Prmary) Hypertension	I10
Hidradenitis Suppurativa	L73.2
Fibromyalgia	M 79.7
Constipation	K59.00

Hospitalizations:

Number of hospitalizations in:	
State Hospitals:	2
Community Hospitals:	8
Where Hospitalized:	
VCBHS, OSH	

Any Stays of 2 years or more?
☐ Yes ☒ No

History of high-risk behaviors:

Please indicate whether the resident displays any of the included high-risk behaviors listed in the available dropdown boxes. Include frequency of behavior and the date of the most recent occurrence of such.

Behavior	Frequency	Most Recent Occurrence
Self-Care Failure	ongoing	
Non-Compliance With Meds		2015/2016
Verbal Assault/Aggression		2013
Physical Assault/Aggresion		
Choose an item.		
Choose an item.		
Choose an item.		

Reason(s) for referral to the nursing facility *(as stated on PASRR form/letter):*

(check all that apply)

- ☒ Needed medication management assistance
- ☒ Needed assistance with Activities of Daily Living and Instrumental Activities of Daily Living
- ☐ Had medical need or needs for special treatments requiring 24-hour nursing care
- ☒ Displayed behaviors not tolerated by the community
- ☒ Exhibited dangerous behaviors
- ☒ Other: If other is checked, please specify

SECTION III SERVICES AND RESOURCES AVAILABLE

The purpose of this section is to build a picture of the service resources, both formal and informal, used by the resident in the course of his or her treatment. Where possible, identify by name or by agency the resource used. If the resident is currently receiving services or support from an agency or individual, indicate this in the "Presently Available" column. In instances where a resource or support will be available to the resident in their community of choice, indicate this availability in the "Would Be Available" column. Information gathered during this section should be kept in mind when completing the Strengths Assessment portion of the screening.

Has lived independently or semi-independently in the past? ☒ Yes ☐ No	
How recently? 2007	For how long? one year
Has used community support services (CSS) in past? ☒ Yes ☐ No	

CMHC RESOURCES	Has Used In Past	Presently Available	Would be available
Case Manager	☒	☐	☒
Psychologist	☐	☐	☒
Therapist	☐	☒	☒
Attendant Care	☐	☐	☒
Crisis Stabilization Services	☐	☒	☒
Medication Assistance	☒	☒	☒
Psychosocial	☒	☒	☒
Psychiatrist	☒	☒	☒
Housing Services	☒	☐	☒
Supported Employment	☒	☐	☒
Supported Education	☒	☐	☒
Other?	☐	☐	☐

FAMILY & FRIENDS **Please identify**	**Has Used In Past**	**Presently Available**	**Would be Available**
John Doe, Sr. Guardian	☒	☒	☒
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

OTHER COMMUNITY RESOURCES	**Has Used In Past**	**Presently Available**	**Would be Available**
Consumer-Run Organizations	☐	☐	☐
Primary Care Physician	☐	☒	☒
Guardian (if applicable) **(If a guardian is indicated, you must include all contact information)**	Name: John Doe, Sr. Address: 1111 Somewhere Dr. #111 Wichita, KS 67218 Phone #: 316-407-0000	☒	☒
Payee (if applicable) **(If a guardian is indicated, you must include all contact information))**	Name: Address: Phone #:	☐	☒
Independent Living Center	☐	☐	☒
Respite Care	☐	☐	☒
In-home skills teaching	☐	☐	☒
Home Health Care	☐	☐	☒
Community Psychologist/ Psychiatrist	☒	☐	☒

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SECTION IV ASSESSMENT OF FUNCTIONAL LIMITATIONS

A. Need for a level of care equal to that provided in an NFMH:

Presence of one or more of the following conditions, despite adequate treatment including a reliable medication regimen, would indicate the need for a level of service equaling the intensity of nursing facility care. These conditions are indicators of the intensity of service needed, not necessarily where the service would be provided.

Note: These categories indicate severe levels of impairment continuing despite intensive treatment. They should not be checked unless there are on-going behaviors causing an inability to complete the majority of activities of daily living even with substantial assistance.

(Check all that apply)

☐	**(1)** Presence of a severe cognitive impairment, or combination of cognitive and physical impairments, which render the individual unable to provide even minimally for their basic health and safety needs (e.g. wandering from their living space with no regard for personal safety, inability to feed themselves or clothe themselves, inability to manage toileting, bathing, etc. either independently or with prompting.) Note: This refers to the lack of the basic skill to accomplish the task, not to the appropriateness of dress, meal choices, or personal hygiene.)
☐	**(2)** Presence of severe psychiatric symptoms which cause extreme withdrawal and social isolation, in combination with a thought disorder which prevents independent or semi-independent functioning for the majority of instrumental activities of daily living such as: shopping, meal preparation, laundry, basic housekeeping, money management, taking medications.
☒	**(3)** Presence of severe psychiatric symptoms which cause frequent socially inappropriate behaviors that are not easily tolerated in the community (e.g. screaming, minor self-abusive acts, inappropriate sexual behavior, verbal harassment of others), or that cause a long-standing pattern of dangerous behaviors (e.g. serious self-harm, violence toward others, fire-setting, etc.) that occur unpredictably and despite on-going aggressive treatment. in combination with a thought disorder which prevents independent or semi-independent functioning for the majority of instrumental activities of daily living such as: shopping, meal preparation, laundry, basic housekeeping, money management, taking medications. List date and nature of most recent episode: 01/19/2017
☐	**(4)** Presence of an on-going alcohol or drug addiction in combination with severe psychiatric symptoms causing a long-standing pattern of dangerous behaviors (e.g. serious self-harm or violence toward others) that occur unpredictably and despite current treatment efforts. List date and nature of most recent episode: _____
☒	**(5)** Medical issues requiring nursing assistance and monitoring. Describe: This past year, John/Jane has been focusing on gaining weight & fixated with using protein drinks, which causes him/ her to have stomach problems during the day & even while sleeping. He/She continue to present poor insight about her medical issues & mental illness, thus requires monitoring/supervision of his/ her meals due to him/her trying to gain weight will eat excessively until sick and start vomiting.

Assistance needed for activities of daily living:

Check the box that best describes the amount of assistance the resident feels they need in the following skill areas. If the NFMH staff indicates a different opinion, space has been provided to indicate both perspectives.

	Resident Assessment	Screener Assessment
1. Taking Medications	1 - Independent	2 - Supervision Needed
2. Managing health care	1 - Independent	2 - Supervision Needed
3. Money management	3 - Assistance Needed	2 - Supervision Needed
4. Grocery shopping	1 - Independent	2 - Supervision Needed
5. Meal preparation & preparation	1 - Independent	2 - Supervision Needed
6. Laundry	2 - Supervision Needed	2 - Supervision Needed
7. Hygiene	1 - Independent	2 - Supervision Needed
8. Housekeeping	1 - Independent	2 - Supervision Needed
9. Structuring free time:		
Weekdays	2 - Supervision Needed	2 - Supervision Needed
Evenings	1 - Independent	2 - Supervision Needed
Weekends	2 - Supervision Needed	2 - Supervision Needed

Additional comments regarding skills: _____

SECTION V POTENTIAL FOR DISCHARGE TO THE COMMUNITY

The assessment of the level of care needs for an NFMH resident must include a comprehensive review of the individual's strengths and goals, as well as, their service, support, and financial needs, and the community's capacity to respond to those needs, prior to the determination that continued nursing facility placement is the best option. Therefore, a "Consumer Strengths Assessment," similar to that used in Community Support Services programs across Kansas, has been included as part of the screening tool. It is strongly recommended that the screening facilitator complete this section of the Screen for Continued Stay. Continuing NFMH care should only be recommended for individuals whose needs cannot be met in the community. Therefore, a review of the community's capacity to provide needed support is a critical piece of the assessment. Both formal and informal sources of support should be considered.

Note: If the screener and facilitator are unfamiliar with services in the resident's home community (or community of choice), the mental health center in that community should be contacted for assistance in identifying the needed resources.

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Strengths Assessment

Consumer's Name

Doe, John/Jane

Facilitator's Name

Peter Capaldi

Current Status: What is going on today? What's available now?	**Individual's Desires, Aspirations:** What do I want?	**Resources, Personal Social:** What have I used in the past?
see attached strengths assessment	**(Life Domain) Daily Living Situation**	
	Financial/Insurance	
	Vocational/Educational	
	Social Supports	

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	Health	
	Leisure/Recreational Supports	
	Spirituality	

What are my priorities?

1. *3.*

2. *4.*

Consumer Comments:	Facilitator's Comments:

Consumer's Signature **Date** **Facilitator's Signature** **Date**

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A. Home Community (List city the resident would choose to return to or move to if he/she were discharged from the NFMH): John/Jane Doe would like to get back to her apartment in Wichita. She still believes she has an apartment there.

B. Resources that would be necessary to assist the individual to live successfully in the community listed above: (If this community is outside of the Screener's catchment area, list name and phone number of person contacted to assist in identification of needed services)

Name: _____ Phone Number: _____

Check all resources that the resident will need in the community. Then, indicate if the resource is an existing resource, or if it is a currently undeveloped one.

Resource Needed		Existing Resource	Resource Not Available/ Developed At This Time
	General Assistance:		
☒	1. Affordable housing or housing subsidy	☒	☐
☒	2. Attendant care services	☒	☐
☒	3. Case management services to assist in goal planning, mobilizing community supports, problem solving, assisting the individual to learn to use available resources, and crisis intervention	☒	☐
☒	4. Community recreational activities	☒	☐
☒	5. Consumer-Run Drop-In Center or social support activities	☒	☐
☒	6. Crisis Stabilization/Respite Program available as needed	☒	☐
☒	7. Housekeeping services	☒	☐
☒	8. In-home medication services (med. drops, prompts to take meds, etc.)	☒	☐
☒	9. Meals-on-Wheels or other nutrition assistance	☒	☐
☒	10. Money management assistance or Conservator or Payee	☒	☐
☒	11. Natural supports, such as family, roommates, friends, church, etc.	☐	☒
☒	12. Psychiatric services and medication management	☒	☐
☒	13. Psychosocial rehabilitation including in-home skills teaching	☒	☐
☒	14. Transportation assistance	☒	☐
☐	15. Vocational assistance	☐	☐
	Medical Assistance:		
☒	16. Assistive devices	☒	☐
☐	17. Personal care services	☐	☐
☐	18. Visiting nurses	☐	☐
☒	19. Friends/Visitors/senior companions or similar program	☒	☐
	Substance Abuse Services:		
☒	20. AA/NA programs appropriate for persons with dual diagnosis	☐	☒
☒	21. Community in-patient chemical dependency treatment	☒	☐
☐	22. Community out-patient chemical dependency treatment	☐	☐
	Other services (list)		
☐	23. _____	☐	☐
☐	24. _____	☐	☐

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SECTION VI SCREENING FINDINGS

Note: Homelessness or lack of financial resources should not be the determining factor for continued nursing facility placement. Case management services should be arranged to assist the individual to access temporary housing, benefits, and community resources for which they may be eligible.

Check A or B.

In cases where the resident's guardian does not support the screening team's recommendation, please list their concerns in the comments section below the "Screener spoke with the guardian" checkbox.

☐ **A. Recommend discharge to the community following development and implementation of an appropriate plan for community supports**

☒ **B. Reasons for continued stay in NFMH** (Indicate reasons below. Check only one.)

☐ **(1)** At this time the resident's level of disability due to mental illness appears to be so severe that even the most intensive community services would be insufficient (refer to Section IV)

☐ **(2)** This person could be served in the community with development of resources listed in the comments section, but at this time, these resources have not been developed.

☐ **(3)** Medical issues necessitate continued stay (please give further detail in the comment section)

☒ **(4)** Other (List below)

Recommendations for additional Community Preparation Skills: John/Jane Doe medications are being adjusted at this time in hopes to stabilize her symptoms & aggression. He/ She has been working with a therapist at times and would recommend that she increase participation with individual therapy to work on conflict resolution skills & appropriate social skills.

Additional Comments: We were unable to complete the interview with John/Jane Doe as she was upset and cursing at screener. John/Jane Doe ended the interview abruptly.

☒ *Screener spoke to the NFMH Administrator or designee at the facility regarding this recommendation.*

Comments David Tennant, ABC XY

☐ *Screener spoke to the guardian regarding this recommendation.*

☐ *Guardian agrees with the screener's recommendation.*

Comments _____

SPMI Criteria: Note whether the individual screened meets criteria for having a "severe and persistent mental illness."

YES ☒ **NO** ☐

If the individual does not meet SPMI criteria, or if additional diagnostic assessment is needed in order to make the determination, or if you question the current diagnosis of record, please explain: _____

SIGNATURES:

Tom Baker — Signature and Credentials of Screener

02/07/2017 — Date

ComCare of Sedgwick County

00Z04ABCS

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Community Mental Health Center | Screener Number

Phone number: Work: 555-555-5555 Cell: 555-555-5555 | Email Address: tom.baker@sedgwick.gov

Matt Smith, ABC XY | 2/8/17

Signature of Qualified Mental Health Professional (QMHP) | Date

Phone number Work: 111-111-1111 Cell: 111-111-1111 | Email Address matt.smith@sedgwick.gov

Within two (2) working days of completing the screen, please email a copy of this form, including the completed Consumer Strengths Assessment, to diana.marsh@ks.gov. If you have any questions about this form, please contact Chris Bush at Chris.Bush@ks.gov or Diana Marsh at Diana.Marsh@ks.gov.

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Screener Qualifications & Job Description

Qualifications

- HS Diploma or Equivalent
- Reviewed the SCS Training Manual and PowerPoint)
- Trained under supervision of a current screener (3 Observations)
- You must also have good interpersonal skills for interacting with people, listening skills to understand their clients' problems, and speaking and writing skills.
- Basic Computer Skills (Data Entry/Emailing/Uploading and Attaching documents

Job Description

The roles and responsibilities of a screener include the scheduling and completion of a "Screen for Continued Stay", as well as recommendations and referrals to appropriate services. These assessments will be conducted in a culturally-sensitive manner with provisions for assessments of non-English speaking individuals. The specific tasks are described below:

The SCS will include completion of the "Stay for Continued Stay." This includes completion of a "Consumer Strengths Assessment" which is incorporated into the SCS document. Screeners and facilitators will complete the assessment documents based on information obtained from a variety of sources including a face to face interview with the individual being screened, review of medical records, discussion with NFMH staff, discussion with family members, guardians, or other individuals as requested by the resident.

Following completion of the assessment documents, the screener and facilitator will each make a recommendation for either discharge to the community upon development and implementation of an appropriate plan for community supports, or continued stay in the NFMH identifying the reason that community discharge is not possible at this time.

If discharge is recommended, once needed services have been determined, the screener will communicate with the Community Support Services (CSS) program where the resident desires to live (either their own CSS program or another if the person chooses to live outside the county of responsibility). A determination will then be made as to whether the supports necessary for discharge to the community are available.

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Facilitator Job Description

The list of Screening Facilitators will be provided to each CMHC with the understanding that former facilitators may still be listed, as KDADS is not notified when someone chooses to no longer participate. The list is only as accurate as the information the Centers provide. From this list, the CMHC will contact the facilitators available in their area to assist with the SCS process. Facilitators will have completed required training and been assigned a number, and will be prepared to provide a friendly, caring, supportive community peer resource to those individuals currently residing in NFMHs. Their assistance will serve to support a smooth and comfortable screening process for the participants. Facilitator responsibilities include:

- Complete the Strengths Assessment portion of the SCS, including recommendations and comments.
- Facilitating the development of one-to-one relationships between consumers living in the community within a given individual's county of responsibility and those individuals currently residing in an NFMH. Facilitators will attempt to foster hope and encouragement as well as identify available resources for those residents who may wish to move from an NFMH back into the community. This relationship may also help residents identify ways in which the NFMH experience contributes to their recovery process.
- Accompanying CMHC staff to various NFMHs for participation in the SCS process.
- Providing peer support throughout the SCS process for those consumers scheduled to be screened.
- Providing information and resources related to community living not only to residents but also to guardians (as applicable), the NFMH staff, and/or the CMHC screeners.

(Please be advised that the list may change overtime with staff turnover)

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Nursing Facilities for Mental Health

Name of Facility	Phone Number	Fax Number
Brighton Place North - **Kayelene** 1301 NE Jefferson Topeka, KS 66608-118	785-233-5127	785-232-2721
Brighton Place West - **Rodney** 331 SW Oakley Ave. Topeka, KS 66606-1914	785-232-1212	785-232-3907
Countryside Health Center - **Gary** 440 Woodland Topeka, KS 66607-2172	785-234-6147	785-232-8781
Golden Living Center of Edwardsville 751 Blake Street **Nicole/Sandy** Edwardsville, KS 66111-1338	913-441-1900	913-422-3442
Golden Living Center of Eskridge 505 N. Main Street - **Ron** Eskridge, KS 66423	785-449-2294	785-449-2285
Haviland Care Center - **Karel** 200 Main Street Haviland, KS 67059-9525	620-862-5291	620-862-5233
Medicalodge of Paola – **Darin** 501 Assembly Lane Paola, KS 66071-1854	913-294-3345	913-294-3115
Providence Living Center – **Brandon** 1112 SE Republican Ave. Topeka, KS 66607-5517	785-233-0588	785-233-5603
Valley Health Care Center - **Bill** 400 12th Street, P.O. Box 189 Valley Falls, KS 66088-0189	785-945-3832	785-945-3708
Westview Manor of Peabody, LLC 500 Peabody, P.O. Box 142 – **Bonita** Peabody, KS 66866-0142	620-983-2165	620-983-2364

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