Hospital and Community Patient Review Instrument (HC-PRI)

RUG II Group (print name)

RHCF Level of Care:
☐ HRF ☐ SNF

Use with separate Hospital and Community PRI Instructions

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER (1-8)

2. SOCIAL SECURITY NUMBER (9-17) - -

3. OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW

4A. PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY)

4B. COUNTY OF RESIDENCE

5. DATE OF PRI COMPLETION

(18-25) - -
MO DAY YEAR

6. MEDICAL RECORD NUMBER/CASE NUMBER (26-34)

7. HOSPITAL ROOM NUMBER (35-39)

8. NAME OF HOSPITAL UNIT/DIVISION/BUILDING

9. DATE OF BIRTH

(40-47) - -
MO DAY YEAR

10. SEX (48) 1=Male 2=Female

11A. DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT

(49-56) - -
MO DAY YEAR

11B. DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE)

(57-64) - -
MO DAY YEAR

12. MEDICAID NUMBER (65-75)

13. MEDICARE NUMBER (76-85)

14. PRIMARY PAYOR (86)
1=Medicaid
2=Medicare
3= Other

15. REASON FOR PRI COMPLETION (87)
1. RHCF Application from Hospital
2. RHCF Application from Community
3. Other (Specify:)

II. MEDICAL EVENTS

16. DECUBITUS LEVEL: ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS. _____

17. MEDICAL CONDITIONS: DURING THE PAST WEEK. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS
1=YES
2=NO

A. Comatose _____
B. Dehydration _____
C. Internal Bleeding _____
D. Stasis Ulcer _____
E. Terminally Ill _____
F. Contractures _____
G. Diabetes Mellitus _____
H. Urinary Tract Infection _____
I. HIV Infection Symptomatic _____
J. Accident _____
K. Ventilator Dependent _____

18. MEDICAL TREATEMENTS: READ THE INSTRUCTIONS FOR THE QUALIFIERS.
1=YES
2=NO

A. Trachesotomy Care/Suctioning (Daily—Exclude self-care) _____
B. Suctioning-General (Daily) _____
C. Oxygen (Daily) _____
D. Respiratory Care (Daily) _____
E. Nasal Gastric Feeding _____
F. Parenteral Feeding _____
G. Wound Care _____
H. Chemotherapy _____
I. Transfusion _____
J. Dialysis _____
K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS) _____
L. Catheter (Indwelling or External) _____
M. Physical Restraints (Daytime Only) _____

III. ACTIVITIES OF DAILY LIVING (ADLs)

Measure the capability of the patient to perform each ADL 60% or more of the time it is performed during the past week (7 days). Read the Instructions for the Changed Condition Rule and the definitions of the ADL terms.

19. EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE: PLATE, CUP, TUBE) 19. (113)

1=Feeds self without supervision or physical assistance. May use adaptive equipment.
2=Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.
3= Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.
4=Totally fed by hand, patient does not manually participate
5=Tube or parenteral feeding for primary intake of food. (*Not* just for supplemental nourishments)

20. MOBILITY: HOW THE PATIENT MOVES ABOUT 20. (114)

1=Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.
2=Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).
3= Walks with *constant* one-to-one supervision and/or constant physical assistance.
4= Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.
5= Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

21. TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET). 21. (115)

1=Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
2=Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.
3=Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.
4=Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.
5=Cannot and is not gotten out of bed.

22. TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN). TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES. 22. (116)

1=Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.
2=Requires *intermittent* supervision for safety or encouragement, or *minor* physical assistance (for example, clothes adjustment or washing hands).
3=Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).
4=Incontinent of bowel *and/or* bladder and is not taken to a bathroom.
5=Incontinent of bowel *and/or* bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

IV. BEHAVIORS

23. VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC. 23. (117)

1=No known history
2=Known history or occurrences, but not during the past week (7 days)
3=Short-lived or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing.)
4=Unpredictable, recurring verbal disruption at least once during the past week (7 days) for no foretold reason
5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions)

24. PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY. (FOR EXAMPLE, HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR) 24. (118)

1=No known history.
2=Known history or occurrences, but not during the past week (7 days).
3=Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.
4=Unpredictable, recurring aggression at least once during the past week (7 days) for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).
5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES *DISRUPTION WITH OTHERS*. (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS. 25. (119)

1=No known history
2=Displays this behavior, but is not disruptive to others (for example, rocking in place).
3=Known history or occurrences, but not during the past week (7 days).
4=Occurences of this disruptive behavior at least once during the past week (7 days)
5=Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).

26. HALLUCINATIONS: EXPERIENCED AT LEAST ONCE DURING THE PAST WEEK. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY. 26. (120)

1=Yes 2=No 3=Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions)

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES: READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS).

A. Physical Therapy (P.T.)

P.T. Level (121)

P.T. Days (122)

P.T. Time (123-126) HOURS MIN/WEEK

B. Occupational Therapy (O.T.)

O.T. Level (127)

O.T. Days (128)

O.T. Time (129-132) HOURS MIN/WEEK

LEVEL
1=Does not receive.
2= Maintenance program-Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.
3=Restorative Therapy-Requires and is currently receiving physical and/or occupational therapy for the past week.
4=Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, therapy provided for only two days).

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS) THAT EACH THERAPY WAS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28. NUMBER OF PHYSICIAN VISITS: DO NOT ANSWER THIS QUESTION FOR HOSPITALIZED PATIENTS, (ENTER ZERO), UNLESS ON ALTERENATE LEVEL OF CARE STATUS. ENTER ONLY THE NUMBER OF VISITS DURING THE PAST WEEK THAT ADHERED TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. THE PATIENT MUST BE MEDICALLY UNSTABLE TO ENTER ANY PHYSICIAN VISITS, OTHERWISE ENTER A ZERO. 28. (133-134)

VI. DIAGNOSIS

29. PRIMARY PROBLEM: THE MEDICAL CONDITION REQUIRING THE LARGEST AMOUNT OF NURSING TIME IN THE HOSPITAL OR CARE TIME IF IN THE COMMUNITY. (FOR HOSPITALIZED PATIENTS THIS MAY OR MAY NOT BE THE ADMISSION DIAGNOSIS).

ICD-9 Code of medical problem 29. - (135-139)

If code cannot be located, print medical name here:

VII. PLAN OF CARE SUMMARY

This section is to communicate to providers any additional clinical information, which may be needed for their preadmission review of the patient. It does not have to be completed if the information below is already provided by your own form, which is attached to this H/C-PRI.

30. DIAGNOSES AND PROGNOSES: FOR EACH DIAGNOSIS, DESCRIBE THE PROGNOSIS AND CARE PLAN IMPLICATIONS.

Primary Prognosis

1.

Secondary (Include Sensory Impairments)

1.

2.

3.

4.

31. REHABILITATION POTENTIAL (INFORMATION FROM THERAPISTS)

A. POTENTIAL DEGREE OF IMPROVEMENT WITH ADLs WITHIN SIX MONTHS (DESCRIBE IN TERMS OF ADL LEVELS ON THE HC-PRI):

B. CURRENT THERAPY CARE PLAN: DESCRIBE THE TREATMENTS (INCLUDING WHY) AND ANY SPECIAL EQUIPMENT REQUIRED.

32. MEDICATIONS

NAME	DOSE	FREQUENCY	ROUTE	DIAGNOSIS REQUIRING EACH MEDICATION

33. TREATMENTS: INCLUDE ALL DRESSINGS, IRRIGATIONS, WOUND CARE, OXYGEN.

A. TREATMENTS	DESCRIBE WHY NEEDED	FREQUENCY

B. NARRATIVE: DESCRIBE SPECIAL DIET, ALLERGIES, ABNORMAL LAB VALUES, PACEMAKER.

34. RACE/ETHNIC GROUP: ENTER THE CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP 34.

1=White	4=Black/Hispanic	7=American Indian or Alaskan Native
2=White/Hispanic	5=Asian or Pacific Islander	8=American Indian or Alaskan Native/Hispanic
3=Black	6=Asian or Pacific Islander/Hispanic	9=Other

35. QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS H/C PRI.

☐YES ☐NO

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

_____ IDENTIFICATION NO.

SIGNATURE OF QUALIFIED ASSESSOR