

**NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING**

INSTRUCTIONS: HOSPITAL AND COMMUNITY PATIENT REVIEW INSTRUMENT

GENERAL CONCEPTS:

1. **PURPOSE:** Pre-admission review to a Residential Health Care Facility (RHCF) from the hospital and community based residences and facilities, such as personal dwelling, domiciliary care facility/adult home and congregate housing.
2. **ASSESSORS:** As qualified through the New York State Department of Health PRI Training Program - hospital discharge planners, certified home health care agency registered nurses, RHCF registered nurses, county public health nurses and other utilization review personnel as designated.
3. **USING THESE INSTRUCTIONS:** These instructions should be read before completing the H/C PRI and should be kept with the H/C PRIs as they are being completed. FREQUENT REFERENCE TO THE INSTRUCTIONS WILL BE NEEDED IN ORDER TO COMPLETE THE H/C PRI ACCURATELY.
4. **ANSWER ALL QUESTIONS:** Answer all questions using the numeric codes provided. DO NOT LEAVE ANY QUESTIONS TOTALLY BLANK. UNUSED BOXES FOR A QUESTION SHOULD REMAIN BLANK. For example, Medical Record Number: / _ / 9 / 6 / 2 / 1 / 0 /. If there are unused boxes, they should be the left side of the number as shown in the example.
5. **QUALIFIERS:** Many of the PRI questions contain multiple criteria which are labeled qualifiers. All qualifiers must be met for a question to be answered "yes." These qualifiers take the following forms.
 - **Time Period:** The time period for the questions is the past week. For the patients who have been in the hospital for less than one week use the time from admission to H/C PRI completion as the time frame. If the community assessor (e.g. certified home health care agency, RHCF assessor) does not have any history on the patient, then the day of the H/C PRI assessment is the timeframe. See "Sources of Information" below.
 - **Frequency –** The frequency specifies how often something needs to occur to meet the qualifier. For example. Suctioning needs to occur daily for at least one week or the PRI cannot be checked for this patient as receiving this care.
 - **Documentation.** Some of the questions require specific medical record documentation to be present. Otherwise, the question cannot be answered "yes" for the patient.
 - **Exclusions -** Some of the questions specifically state to omit certain types of care or behavior when answering the question. For example, inhalators are excluded from oxygen therapy.
6. **SOURCES OF INFORMATION:** For community based referred patients, the sources of information may not be as accessible as in the hospital. Discussion with the patient's family members, other caregivers and personal physician(s) will help provide more accurate information. The patient may be receiving community services or may have in the past.
7. **ACTIVITIES OF DAILY LIVING (ADLs):** The approach to measuring ADLs is slightly different from other PRI questions. Measure how capable the patient is in completing each ADL sixty percent (60%) or more of the time that it needs to be performed. **CAPABILITY:** Reviewing the patient's

physical and mental status, measure the present capability of the patient to perform each ADL. This is in contrast to how the patient may be actually performing the ADLs in the hospital/facility or in the community. Read the specific instructions on ADLs to understand the CHANGED CONDITION RULE, the specific ADL definitions and the measurement of capability.

8. CORRECTIONS: Cross out any response which you wish to change and reenter clearly to the right of the original response. Example: /3/4

INSTRUCTIONS: H/ C-PRI QUESTIONS

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER: Enter the seven (7) or eight (8) character identifier stated on the facility's / agency operating certificate. For a hospital there will always be seven (7) numbers followed by an "H" in the eighth box. For a certified home health agency and a county Department of Health, there will only be seven (7) numbers with no letters. This means that the first answer box to the left will remain blank. For a residential health care facility, there will be seven (7) numbers followed by a "P", for a health related facility (HRF) or an "N" for a skilled nursing facility (SNF).
2. SOCIAL SECURITY NUMBER: Do not leave blank; enter zero in far right hand box if patient does not have a number
3. OFFICIAL FACILITY NAME: Print the formal name of the hospital/community agency, etc.
4. PATIENT NAME: When completing the H/C PRI do not use nicknames. Print last name first (e.g., Brant, Diana C).
6. MEDICAL RECORD NUMBER/CASE NUMBER: Enter the unique number assigned by the hospital/agency to identify each patient. It is not the Medicaid, Medicare or Social Security number, unless that is the number used to identify patients. If there is no assigned case number for the community based patient, leave this question blank.
7. HOSPITAL ROOM NUMBER: Enter the numbers and/or letters which identify the patient's room in the hospital or other applicable community facility. If the patient is residing in the community when the H/C-PRI review is completed, then print the address in Question 4, "Patient Name."
(Community is defined as a personal dwelling, Adult Home, congregate housing or other domiciliary type of facilities/dwellings.)
8. NAME OF HOSPITAL UNIT/BUILDING/DIVISION: Print the name of the hospital unit, such as "med-surgery," where the patient was reviewed. Include any other unique hospital location identifiers, such as specific building names where the unit is located. However, if the patient has changed units or buildings or will be moving, then print instead where the patient can be located in the future (if known). If the patient is reviewed in the community, then this question is not applicable and can be left blank.
- 11A. DATE OF HOSPITAL ADMISSION OR INITIAL Enter in numerical format the month, day and year the patient was admitted to this hospital for purposes of this

AGENCY VISIT: review. (Use most recent hospitalization date for multiple hospitalizations.) Do not include the date of Alternate Level of Care status, rather enter this date, if applicable, in Question 11B.

If the patient is being reviewed in the community, enter the date of the initial patient visit by the certified home health care agency, nursing home or any other qualified agency/organization. This visit may be a followup to a referral made by the patient, the patient's family, the patient's physician, etc.

- 11B. DATE OF ALTERNATE LEVEL OF CARE STATUS: Enter in numerical format the day, month and year the patient went onto Alternate Level of Care status (ALC) in the hospital. If the patient has entered ALC status more than once during this hospital stay, enter the most recent ALC admission date. (That is, this patient was on ALC status, but was discharged because of an acute episode and then went back to ALC status.) If the patient is not on ALC status or is in the community during this review, enter a zero (0) in the far right hand box.
12. MEDICAID NUMBER: Enter these numbers if patient has such coverage
13. MEDICARE NUMBER: Available, whether or not coverage is being used. If not, enter only one zero (0) in the far right hand box.
14. PRIMARY PAYOR: Enter the one source of coverage which pays for most of the patient's current hospitalized stay; for patients in the community enter what is covering the patient's community health care needs. Code "other" only if the primary payor is not Medicaid or Medicare. "Other" includes self-pay and private insurance.
15. REASON FOR PRI COMPLETION: Select the one reason why the PRI is being completed. This is for preadmission review purposes.
- # 1 RHCF Application from Hospital means the patient resides in the hospital at the time of this H/C-PRI review and is applying for admission into a residential health care facility (RHCF, HRF or SNF). This H/C-PRI is being completed by a qualified hospital assessor or another qualified assessor (i.e. RHCF assessor, certified home health care assessor) who enters the hospital to review the patient.
- # 2 RHCF Application for Community means the patient resides in the community during this H/C-PRI review. Include Adult Homes and other domiciliary care facilities.

II. MEDICAL EVENTS

16. DECUBITUS LEVEL: Enter the level of skin breakdown (located at pressure points) using the qualifiers stated below:
- DOCUMENTATION - For a patient to be cited as level 4, documentation by a licensed clinician must exist which describes the following three components:

- A description of the patient's decubitus.
- Circumstances or medical condition which leads decubitus.
- An active treatment plan.

DEFINITION
LEVELS:

# 0	No reddened skin or breakdown.
# 1	Reddened skin, potential breakdown.
# 2	Blushed skin, dusty colored, superficial layer of broken or blistered skin.
# 3	Subcutaneous skin is broken down.
# 4	Necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia and bone.
# 5	Patient is at a level 4, but the documentation qualifier has not been met.

17. MEDICAL CONDITIONS: For a YES to be answered for any of these conditions, all of the following qualifiers must be met:

Time Period -	Condition must be existed during the past week.
Documentation -	Written support exists that the patient has the condition.
Definitions -	See chart below. (Examples are for clarification and are not intended to be all-inclusive.)

		Definition	Examples of Causes	Examples of Treatment
17A	COMATOSE:	Unconscious, cannot be aroused, and at most can respond only to powerful stimuli. The coma must be present for at least four days.	Brain insult Hepatic encephalopathy Cardiovascular accident	Total ADL intake & output Parenteral feeding
17B	DEHYDRATION:	Excessive loss of body fluids requiring immediate medical treatment and ADL care.	Fever Acute urinary tract infections Pneumonia Vomiting Unstable diabetes	Intake & output Electrolyte lab tests Parenteral hydration Nasal feedings
17C	INTERNAL BLEEDING:	Blood loss stemming from a subacute or chronic condition (e.g., gastrointestinal, respiratory or genito-urinary conditions) which may result in low blood pressure and hemoglobin, pallor, dizziness, fatigue, rapid respiration.	Use only the causes presented in the definition. Exclude external hemorrhoids and other minor blood loss which is not dangerous and requires only minor intervention.	Critical monitoring of vital signs Transfusion Use of blood pressure elevators Plasma expanders Blood every 60 days likely to be needed
17D	STASIS ULCER:	Open lesion, usually in lower extremities, caused by decreased blood flow from chronic venous insufficiency.	Severe edema Diabetes PVD	Sterile dressing Compresses Whirlpool Leg elevation

17E	TERMINALLY ILL:	Professional prognosis (judgment) is that patient is rapidly deteriorating and will likely die within three (3) months.	End stages of: carcinoma, renal disease, Cardiac disease	ADL Care Social/emotional support
17F	CONTRACTURES:	<p>A shortening and tightening of ligaments and muscles resulting in loss of joint movement. Determine whether range of motion loss is actually due to contractures and not only due to spasticity paralysis or joint pain.</p> <p>It is important to observe the patient to confirm whether a contracture exists and check the chart for confirmatory documentation.</p> <p>To qualify as "Yes" on the H/C PRI the following qualifier must be met:</p> <ol style="list-style-type: none"> 1. The contracture must be documented by a physician, physical therapist or occupational therapist. 2. The status of the contracture must be reevaluated and documented by the physician, physical therapist or occupational therapist on an annual basis. <p>There does not need to be an active treatment plan to enter "Yes" to contractures.</p>		
17G	DIABETES MELLITUS:	A metabolic disorder in which the ability to oxidize carbohydrates is compromised due to inadequate pancreatic activity resulting in disturbance of normal insulin production. This may or may not be the primary problem (Q.29) or primary diagnosis. It should be diagnosed by a physician. Include any degree of diabetes, stable	<p>Destruction/malfunction of the pancreas</p> <p>Exclude hypoglycemia or hyperglycemia which may be a diabetic condition, but by itself does not constitute diabetes mellitus.</p>	<p>Special diet</p> <p>Oral agents</p> <p>Insulin</p> <p>Exercise</p>

		or unstable, and any manner it is controlled.		
17H	URINARY TRACT INFECTION:	<p>During the past week, signs and symptoms of a UTI have been exhibited or it has been diagnosed by lab tests. Symptoms may include frequent voiding, foul smelling urine, voiding small amounts, cloudy urine, sediment and an elevated temperature. May or may not be the primary problem under Q.29. Include as a UTI if it has not been confirmed yet by lab tests, but the symptoms are present. Include patients who appear asymptomatic, but whose lab values are positive (e.g., mentally confused or incontinent patients)</p>	Exclude if symptoms are present, but the lab values are negative	Antibiotics Fluids
17I	HIV INFECTION SYMPTOMATIC:	<p>HIV (Human Immunodeficiency Virus) Infection, Symptomatic Includes: Acquired Immunodeficiency Syndrome (AIDS) and HIV related illnesses. The patient has been tested for HIV infection and a positive finding is documented AND the patient has had symptoms, documented by a physician as related to the HIV infection.</p> <p>Symptoms include but are not limited to abnormal weight loss, respiratory abnormalities, anemia, persistent fever, fatigue and diarrhea. Symptoms need not have occurred in the past four weeks. Exclude patients who have tested positive for HIV infection and have not become symptomatic, and patients who have not received the results of the HIV test.</p>		

- 17J. ACCIDENT: An event resulting in serious bodily harm, such as, a fracture, a laceration which requires closure, a second or third degree burn or any injury requiring admission to a hospital.
To qualify as "YES" on the H/C PRI the following qualifier must be met:
1. During the past six (6) months serious bodily harm occurred as the result of one (1) or more accidents.
- 17K VENTILATOR DEPENDENT: A patient who has been admitted to a skilled nursing facility on a ventilator or has been ventilator dependent within five (5) days prior to admission to the skilled nursing facility. Patients who are in the process of being weaned off of ventilator support will qualify for this category for one month after extubation if they are receiving active respiratory rehabilitation services during that period. Patients in the facility who decompensate and require intubation also qualify for this category.
- All services shall be provided in accordance with Part 416.13, Part 711.5 and 713.21 of Chapter V of Title 10 of the Official Compilation of Codes Rules and Regulations of the State of New York.
18. MEDICAL TREATMENTS: For a "YES" to be answered for any of these, the following qualifiers must be met:
- Time Period - Treatment must have been given during the past week and is still required.

Frequency - As specified in the chart below.

Documentation - Physician order specifies that treatment should be given and includes frequency as cited below, where appropriate.

Exclusions - See Chart on the below.

		DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
18A.	TRACHEOSTOMY CARE:	Care for a tracheostomy, including suctioning. Exclude any self-care patents who do not need daily staff help.	Daily for the past week (7 days) or will continue to be required for seven days.	Self-care patients
18B.	SUCTIONING:	Nasal or oral techniques for clearing away fluid or secretions. May be for a respiratory problem.	Daily for the past week (7 days) or will continue to be required for seven days.	Any tracheotomy suctioning
18C.	OXYGEN THERAPY:	Administration of oxygen by nasal catheter, mask (nasal or oronasal), funnel/cone, or oxygen tent for conditions resulting from oxygen deficiency (e.g., cardio-pulmonary condition).	Daily for the past week (7 days) or will continue to be required for seven days.	Inhalators Oxygen in room, but not in use
18D.	RESPIRATORY CARE:	Care for any portion of the respiratory tract, especially the lungs (for example COPD, pneumonia). This care may include one or more of the following: Percussion or cupping, postural drainage, positive pressure machine, possibly oxygen to administer drugs, etc.	Daily for the past week (7 days) or will continue to be required for seven days.	Suctioning
18E.	NASAL GASTRIC FEEDING:	Primary food intake is by a tube inserted into nasal passage; resorted to when it is the only route to the stomach	None	None Gastrostomy not applicable
18F.	PARENTERAL FEEDING:	Intravenous or subcutaneous route for the administration of fluids used to maintain fluid, nutritional intake, electrolyte balance (e.g., comatose, damaged stomach)	None	None Gastrostomy not applicable
18G.	WOUND CARE:	Subcutaneous lesion(s) resulting from surgery, trauma, or open cancerous ulcers.	Care has been provided or is professionally judged to be needed for at least three consecutive weeks	Decubiti Stasis ulcers Skin tears Feeding Tubes

18H.	CHEMOTHERAPY:	Treatment of carcinoma through IV and/or oral chemical agents, as ordered by a physician. (Community based patient may have to go to a hospital for treatment.)	None	None
18I.	TRANSFUSIONS:	Introduction of whole blood or blood components directly into the blood stream. (Community based patients may have to go to a hospital for treatment.)	None	None
18J.	DIALYSIS:	The process of separating components, as in kidney dialysis (e.g., renal failures, leukemia, blood dyscrasia. Community based patients may have to go to a hospital for treatment.)	None	None
18K.	BOWEL AND/OR BLADDER REHABILITATION:	The goal of this treatment to gain or regain optimal bowel and/or bladder function and to re-establish a pattern. It is much more than just a toileting schedule or a maintenance/conditioning program. Rather it is an intense treatment which is very specific and unique for each patient and is of short term duration. (i.e., usually not longer than six weeks). NOT all patients at level five under toileting Q.22 may be a "Yes" with this question. The specific definition for bladder rehabilitation differs from bowel rehabilitation; refer below:	Very specific and unique for each patient.	Maintenance toileting schedule. Restorative toileting program but does not meet the treatment requirements specified in the definition.
	Bladder Rehabilitation:	Will generally include these step-by-step procedures which are closely monitored, evaluated and documented: (1) mental & physical assessment of the patient to determine training capacity; (2) a 24 hour flow sheet or chart documenting voiding progress; (3) possibly increased fluid intake during the daytime; (4) careful attention to skin care; (5) prevention of constipation; (6) in the beginning may be		

toileted 8 to 12 times per day with decreased frequency with progress.

Bowel rehabilitation:	A program to prevent chronic constipation/impaction. The plan will generally include: (1) assessment of bowel movements, relevant medical problems, medication use; (2) a dietary regimen of increased fluids & bulk (e.g., bran, fruits); (3) regular toileting for purposes of bowel evacuation; (4) use of glycerine suppositories or laxatives; (5) documentation on a worksheet or Kardex.		Exclude a bowel maintenance program which controls bowels incontinence by development of a routine bowel schedule
18L. CATHETER:	During the past week an indwelling or external catheter has been needed. The indwelling catheter has been used for any duration during the past week; a physician order is present. The external catheter was used on a continuous basis (with proper removal and replacement during this period) for one or more days during the past week; a physician order is not required.		Exclude catheters used to empty the bladder once, secure a specimen or instill medication.
18M. PHYSICAL RESTRAINTS:	A physical device used to restrict patient movement. Physical restraints include belts, vests, cuffs, mitts, jackets, harnesses, and geriatric chairs.	At least two (2) continuous daytime hours anytime during the past week, (7 days).	Exclude all of the following: Medication used for the sole purpose of modifying patient behavior Application only at night
	To Qualify as "Yes" on the H/C PRI the following qualifiers must be met: 1. The restraint must have been applied for at least two continuous daytime hours anytime during the past week, seven (7 days). Daytime includes the time from when the patient gets up in the morning to when the patient goes to bed at night.		Application for less than two (2) continuous daytime hours Devices which the patient can release/remove such as velcro seatbelts on wheelchairs Patients who are bed bound Siderails, locked doors/gates, domes

2. An assessment of need for the physical restraint must be written by M.D. or R.N.
3. The comprehensive care plan based on the assessment must include a written physician's order and specific nursing interventions regarding use of the physical restraint.

III. ACTIVITIES OF DAILY LIVING: EATING, MOBILITY, TRANSFER, TOILETING

Use the following qualifiers in answering each ADL question:

Time Period - Past week (7 days).

Frequency - Assess the capability level of the patient to perform each ADL 60% or more of the time performed since the ADL status may fluctuate during a 24 period.

CHANGED CONDITION RULE: When a patient's ADL has improved or deteriorated during the past week (7 days) and this course is unlikely to change, measure the ADL according to its present status.

MEASUREMENT APPROACH: Measure the present capability of the patient to complete each ADL. This may be in contrast to what the patient may actually be doing. The reason why you are assessing capacity, rather than actual performance, is so that only patient characteristics are taken into account when measuring ADLs. Omit nonpatient considerations when assessing ADLs. For example, physical barriers, such as stairs or no ramps, may prevent the patient from performing ADLs at the level s/he is actually capable. Or facility safety policy or clinical order, such as bedrest, may prevent the patient from performing ADLs. Or informal supports in the community or hospital staff may be providing more assistance with ADLs (e.g., toileting) than the patient actually needs.

Definitions - **SUPERVISION:** means verbal encouragement and observation, not physical hands on care.

ASSISTANCE: means physical hands-on care.

INTERMITTENT: means that a staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis

CONSTANT: means one-to-one care that requires a staff person to be present during the entire activity. If the staff person is not present, the patient will not complete the activity.

Note how these terms are used together in the ADLs. For example, there is intermittent supervision and intermittent assistance.

CLARIFICATION OF ADL RESPONSES

19. EATING: # 3 "Requires continual help..." means that the patient requires a staff person's continual presence and help for reasons such as: patient tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat.
- # 5 "Tube or parenteral feeding..." means that all food and drink is given by nursing staff through the means specified.
20. MOBILITY: # 3 "Walks with constant supervision and/or assistance..." may be required if the patient cannot maintain balance, has a history of falls, has stress fracture potential, or is relearning to ambulate.
21. TRANSFER: # 4 "Requires two people..." may be required for reasons such as: the patient is obese, has contractures, has fracture (or stress fracture potential), has attached equipment that makes transfer difficult (for example, tubes). There must be logical medical reasons why the patient needs the help of two (2) people to transfer. This reason should be documented in the medical record.
- Exclude transfers to bath or toilet
- # 5 "Bedfast..." may refer to a patient with acute dehydration, severe decubitus, or terminal illness.
22. TOILETING: Definition- INCONTINENT - 60% or more of the time, the patient loses control of his/her bladder or bowel functions, with or without equipment.
- # 1 "Continent ...Requires no or intermittent supervision" and # 2 "...and/or assistance" can refer to the continent patient or the incontinent patient who needs no/little help with his/her toileting equipment (for example, catheter).
- # 3 "Continent... Requires constant supervision/total assistance..." refers to a patient who may not be able to balance him/herself and transfer, has contractures, has a fracture, is confused or is on a rehabilitation program. In addition this level refers to the patient who needs constant help with elimination/incontinence appliances (for example, colostomy, ileostomy).
- # 4 "Incontinent... Does not use a bathroom" refers to the patient who does not go to a toilet room, but instead may use a bedpan or continence pads. This patient may be bed-bound or is mentally confused to the extent that a scheduled toileting program is not beneficial.
- # 5 "Incontinent... Taken to a bathroom..." refers to the patient who is on a formal toileting schedule, this should be documented in the medical record. This patient may be on a formal bowel and bladder rehabilitation program to regain or maintain control, or the toileting pattern is known and it is better psychologically and physically for the patient to be taken to the toilet (for example, to prevent decubiti).

A patient may have different levels of toileting capacity for bowel and bladder function. To determine the level of such a patient, note that level four and five refer to incontinence of either bladder or bowel. Thus if a patient receives the type of care described in one of these levels for either type of incontinence, enter that level.

Example 1: A patient needs constant assistance with a catheter (level 3) and is incontinent of bowel and is taken to the bathroom every four hours (level 5). In this instance, enter level 5 on the PRI because he is receiving the type of care described in this question for bowel incontinence.

Example 2: The patient requires intermittent supervision for bowel function (level 2), and is taken to the toilet every two hours to a bladder rehabilitation program. Enter level 5, as the patient is receiving this type of care for bladder incontinence

IV. BEHAVIORS: VERBAL DISRUPTION, PHYSICAL AGGRESSION, DISRUPTIVE, INFANTILE/ SOCIALLY INAPPROPRIATE BEHAVIOR, AND HALLUCINATIONS

The following qualifiers must be met:

Time Period - Past week (7 days).

Frequency - As stated in the responses to each behavioral question.

Documentation - To qualify a patient as LEVEL 4 or to qualify the patient as a "YES" to HALLUCINATIONS, the following conditions must be met:

- Active treatment plan for the behavioral problem must be in current use.
- Psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem. This assessment must still be exhibited by the patient.

Definitions - The terms used on the PRI should be interpreted only as they are defined below:

- **PATIENT'S BEHAVIOR:** Measure it as displayed with the behavior modification and treatment plan in effect during the past week.
- **DISRUPTION:** Through verbal outbursts and/or physical actions, the patient interferes with the staff and/or other patients. This interference causes the staff to stop or change what they are doing immediately to control the situation. Without this staff assistance, the disruption would persist or a problem would occur.
- **NONDISRUPTION:** Verbal outbursts and/or physical actions by the patient may be irritating, but do not create a need for immediate action by the staff.
- **UNPREDICTABLE BEHAVIOR:** The staff cannot predict when (that is, under what circumstances) the patient will exhibit the behavioral problem. There is no evident pattern.
- **PREDICTABLE BEHAVIOR:** Based upon observations and experiences with the patient, the staff can discern when a patient will exhibit a

behavioral problem and plan appropriate responses in advance. The behavioral problem may occur during activities of daily living (for example, bathing), specific treatments (for example, contracture care, ambulation exercises), or when criticized, bumped into, etc.

CLARIFICATION OF RESPONSES TO BEHAVIORAL QUESTIONS

23. VERBAL DISRUPTION: Exclude verbal outbursts/expressions/utterances which do not create disruption as defined by the PRI.
24. PHYSICAL AGGRESSION: Note that the definition states "with intent for injury"
25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: Note that the definition states that this behavior is physical and creates disruption. EXCLUDE the following behaviors:
- Verbal outbursts
 - Social Withdrawal
 - Hoarding
 - Paranoia
26. HALLUCINATIONS: For a "YES" response, the hallucinations must have occurred at least once during the past week (7 days) (in addition to meeting the other qualifiers above for an active treatment plan and psychiatric assessment).

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES:
- For each therapy these three types of information will be entered on the PRI: "Level", "Days" and "Time" (hours and minutes).
 - For a patient not receiving a therapy at all, the "Level" will always be entered in the answer key as # 1 ("does not receive"), the "Days" will be entered 0 (zero) and the "Time" will both be 0 (zero).
 - Use the chart below to understand the qualifiers for each of the three (3) types of information that will be entered. Whether a patient is receiving maintenance or restorative therapy will make a difference in terms of the qualifiers to be used. SEE CHART BELOW FOR THE SPECIFIC QUALIFIERS.

QUALIFIERS FOR LEVEL	MAINTENANCE THERAPY= LEVEL 2	RESTORATIVE THERAPY = LEVEL 3	QUALIFIERS NOT MET = LEVEL 4
DOCUMENTATION QUALIFIERS: POTENTIAL FOR INCREASED FUNCTIONAL/ADL ABILITY	No potential for increased functional ADL ability. Therapy is provided to maintain and/or retard deterioration of current functional/ADL status. Therapy plan of care and progress notes should support that	There IS positive potential for improved functional status within a short and predictable period of time. Therapy plan of care and progress notes should support that patient has this potential/is improving.	ENTER LEVEL 4 IF ANY ONE OF THE QUALIFIERS UNDER QUALIFIERS LEVELS 2 OR 3 IS NOT MET.

patient has no potential for further or any significant improvement.

PHYSICIAN ORDER QUALIFIER	Yes	Yes, monthly	Enter Level 4 if
PROGRAM DESIGN AND EVALUATION QUALIFIER	Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.	Licensed professional person with a 4 year specialized therapy degree evaluates program on a monthly basis.	any one (1) of the qualifiers
TIME PERIOD QUALIFIER	Treatments have been provided during the past week.	Treatments have been provided during the past week.	under Levels 2
NEW ADMISSION QUALIFIER	Not Applicable	New admissions of less than one week can be marked for restorative therapy if: <ul style="list-style-type: none"> • There is a physician order for therapy and patient is receiving it. • A new admission includes re-admissions to a residential health care facility. 	or 3 is not met.

27. DAYS AND TIME PER WEEK QUESTION: QUALIFIER

QUALIFIERS FOR DAYS AND TIMES*	MAINTENANCE THERAPY (i.e, level 2 or 4 under "level" question)	RESTORATIVE THERAPY (i.e., If level 3 or 4 under "Level" question) <ul style="list-style-type: none"> • The licensed therapist has documented in the care/plan that therapy is needed for at least one week.
TYPE OF THERAPY SESSION	Count only one-to-one care. Exclude group session (e.g., PT exercise session, OT cooking session).	Count only one-to-one care. Exclude group session (e.g., PT exercise session, OT cooking session).
SPECIALIZED PROFESSIONAL ON-SITE (ON-SITE MEANS IN WITHIN THE FACILITY)	A certified (2 year) or licensed (4 year) specialized professional is on-site supervising or providing therapy.	A licensed (4 year) specialized professional is on-site supervising or providing care. (Do not include care provided by PT or OT aides.)

* QUALIFIERS NOT MET: DO NOT ENTER ON THE PRI ANY DAYS AND TIME OF THERAPY WHICH DO NOT MEET BOTH THESE QUALIFIERS UNDER EACH TYPE OF THERAPY.

28. NUMBER OF PHYSICIAN VISITS: Enter "0" (zero) unless the patient need qualifiers stated below are met. If and ONLY if, the patient meets all the patient need qualifiers, then enter the number of physician visits that meet the physician visit qualifiers.

- Do not answer this question for hospitalized patients, unless on Alternate Level of Care status. Enter "0" (zero).
PATIENT TYPE/NEED QUALIFIERS: The patient has a medical condition that is (1) unstable and changing; or (2) is stable, but there is high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative).
- PHYSICIAN VISIT QUALIFIER: If, and only if, the patient meets the PATIENT TYPE/NEED QUALIFIER, then enter the number of physician visits during the past week that meets the following qualifications:
 - A visit qualifies only if there is physician documentation that s/he has personally examined the patient to address the pertinent medical problem. The physician must make a notation or documentation in the medical record as to the result of the visit for the unstable medical condition (e.g., change medications, renew treatment orders, nursing orders, order lab tests).
 - Do not include phone calls as a visit nor visits which could be accomplished over the telephone.
 - For community based patient, the physician visit may occur in the patient's own home, physician's office, outpatient clinic or hospital.

DIAGNOSIS

29. PRIMARY MEDICAL PROBLEMS: Follow the guidelines stated below when answering this question.

- NURSING TIME: The primary medical problem should be selected based on the condition that has created the most need for nursing time during the past week (7 days). A review of the medical record for nursing and physician notes during the past week may be necessary. For community

based patients review what is requiring the most care time from informal supports and health care professionals if any.

- JUDGMENT: This decision may require the assessor to use her/his own professional judgment in deciding upon the primary problem.
- ICD-9: Refer to the ICD-9 codes for common diagnoses (attached at the end of these instructions) for easy access to most frequently used numbers. An ICD-9 code book containing the complete ICD-9 listing should be available in the nursing and/or medical records office of a facility.
- NO ICD-9 NUMBER: Enter "0" (zero) in the far right box if no ICD-9 number can be found for the patient's primary problem (or if the patient does not have a primary medical problem). If you cannot locate the ICD-9 code for the primary medical problem, PRINT THE NAME OF THE PRIMARY MEDICAL PROBLEM in the space provided on the PRI.

NOTE: If the patient has AIDS or HIV related illnesses, indicate this in Section II, Medical Events, Item 17F. Do not use AIDS or HIV specific ICD codes (042-044). Instead, use the code of the specific problem requiring the most caregiver time. For example, for all patients for whom viral pneumonia (NOS) is the condition requiring the most caregiver time, enter 480.9. Do not enter 042.1 for patients with HIV Infection.

34. RACE/ETHNIC GROUP:

The following definitions are to be utilized in determining race and ethnic groups:

1. WHITE: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.
2. WHITE/HISPANIC: A person who meets the definition of both White and Hispanic. (see Hispanic below)
3. BLACK: A person having origins in any of the Black racial groups of Africa.
4. BLACK/HISPANIC: A person who meets the definition of both Black and Hispanic (see below)
5. ASIAN or PACIFIC ISLANDER: A person having origins in any of the original people of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.
6. ASIAN or PACIFIC ISLAND/HISPANIC: A person who meets the definition of both Asian or Pacific Islander and Hispanic (see below).
7. AMERICAN INDIAN or ALASKAN NATIVE: A person having origins, in any of the original people of North America and who maintains tribal affiliation or community recognition.
8. AMERICAN INDIAN or ALASKAN NATIVE/HISPANIC: A person who meets the definition of both American Indian or Alaskan Native and Hispanic (see below).

9. OTHER: Other groups not include in previous categories.
- HISPANIC: A person having origins of Puerto Rican, Mexican, Cuban, Dominican, Central or South American, or other Spanish Culture or origins.
35. QUALIFIED ASSESSOR: The individual who has completed and/or reviewed the PRI. To be complete, each assessment must be signed by the qualified nurse assessor.