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

LDSS-3139 (3/79)

DEPARTMENT OF HEALTH

OFFICE OF HEALTH SYSTEMS MANAGEMENT

HOME ASSESSMENT ABSTRACT

GENERAL INSTRUCTIONS:

THIS FORM MUST BE COMPLETED FOR ALL LONG TERM HOME HEALTH CARE PROGRAM PATIENTS AND ALL MEDICAID PATIENTS RECEIVING HOME HEALTH AIDE OR PERSONAL CARE SERVICES. PORTIONS AS INDICATED MUST BE COMPLETED BY RESPECTIVE PERSONNEL FOR THE ABOVE MENTIONED PURPOSES. FOR MORE INFORMATION, SEE DETAILED INSTRUCTIONS.

ABBREVIATIONS:

CHHA – CERTFIED HOME HEALTH AGENCY
LTHHCP – LONG TERM HOME HEALTH CARE PROGRAM
RN – REGISTERED NURSE
SSW – SOCIAL SERVICE WORKER
INSTRUCTION PAGE 1:
TO BE COMPLETED BY RN – PARTS 1, 2, 3
TO BE COMPLETED BY SSW – PARTS 1, 2, 3, 4, 5, 6

1. REASON FOR PREPARATION

☐ ADMISSION TO LTHHCP
☐ INITIAL EVALUATION FOR HOME HEALTH AIDE
☐ INITIAL EVALUATION FOR PERSONAL CARE
☐ REASSESSMENT FROM _____ TO _____
☐ LTHHCP ☐ CHHA ☐ PERSONAL CARE
☐ OTHER, SPECIFY _____

2. PATIENT NAME

RESIDENT ADDRESS APT. NO.

CITY STATE ZIP TEL. NO.

ADDRESS WHERE PRESENTLY RESIDING TEL. NO.

DIRECTIONS TO CURRENT ADDRESS

SOCIAL SERVICES DISTRICT FIELD OFFICE

4. NEXT OF KIN/GUARDIAN

STREET

CITY STATE ZIP

RELATION TEL NO.

3. CURRENT LOCATION/DIAGNOSIS OF PATIENT

☐ HOSP. ☐ HRF ☐ HOME
☐ SNF ☐ DCF ☐ OTHER (SPECIFY)

NAME OF FACILITY/ORGANIZATION

STREET

CITY STATE ZIP TEL NO.

DATE ADMITTED PROJECTED DISCHARGE DATE

DIAGNOSIS

5. NOTIFY IN EMERGENCY

NAME

CITY STATE ZIP

RELATION TEL NO.

PATIENT INFORMATION

6. DATE OF BIRTH _____ AGE _____

LANGUAGE(S) SPOKEN/UNDERSTANDS _____

SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED ☐ SEPARATED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ UNKNOWN

LIVING ARRANGEMENTS:

☐ ONE FAMILY HOUSE ☐ HOTEL
☐ MULTI-FAMILY HOUSE ☐ APT.
☐ FURNISHED ROOM ☐ BOARDING HOUSE
☐ SENIOR CIT. HOUSING ☐ IF WALK-UP (# FLIGHTS ___)
☐ OTHER, SPECIFY _____

LIVES WITH: ☐ SPOUSE ☐ ALONE ☐ OTHER _____

SOCIAL SECURITY NO. _____

MEDICARE NO. PART A _____
PART B _____

MEDICAID NO. _____ ☐ PENDING

BLUE CROSS NO. _____

WORKMENS COMP. _____

VETERANS CLAIM NO. _____

VETERANS SPOUSE ☐ YES ☐ NO

OTHER (SPECIFY) _____

SOURCE OF INCOME/OTHER BENEFITS

☐ SOCIAL SECURITY
☐ PUBLIC ASSIST.
☐ VETERANS BENEFITS
☐ PENSION
☐ FOOD STAMPS
☐ S.S.I.
☐ OTHER (SPECIFY) _____

AMOUNT OF AVAILABLE FUNDS AFTER PAYMENT OF RENT, TAXES UTILITIES, ETC. _____

7. **To be completed by S S W**
OTHERS IN HOME/HOUSEHOLD: Indicate days/hours that these persons will provide care to patient.
If none will assist explain in narrative.

	NAME	Age	Relationship	Days/Hours at Home	Days/Hours will Assist
1.					
2.					
3.					
4.					

8. To be completed by S S W
SIGNIFICANT OTHERS OUTSIDE OF HOME: Indicate days/hours when persons below will provide care to patient.

	Name	Address	Age	Relationship	Days/Hours Assisting
1.					
2.					
3.					
4.					
5.					

9. To be completed by S S W
COMMUNITY SUPPORT: Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

	Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.					
2.					
3.					
4.					

10. To be completed by S S W and R.N.
PATIENT TRAITS:

	Yes	No	?N/A	If you check No. ?N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts diagnosis				
Motivated to remain at home				

11. To be completed by S S W and R.N. as appropriate
FAMILY TRAITS:

	Yes	No	?	
a. Is motivated to keep patient home				If no, because
b. Is capable of providing care (physically & emotionally)				If no, because
c. Will keep patient home if not involved with care				Because
d. Will give care if support service given				How much
e. Requires instruction to provide care				In what – who will give

12. To be completed by R.N.

Home/Place where care will be provided:	Yes	No	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, other (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/ caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

ADDITIONAL ASSESSMENT FACTORS: _____

13. To be completed by R.N.
RECOVERY POTENTIAL ANTICIPATED — COMMENTS

Full recovery	☐	
Recovery with patient management residual	☐	
Limited recovery managed by others	☐	
Deterioration	☐	

14. To be completed by R.N. – S S W to complete "D" as appropriate
FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED

SERVICES REQUIRED	YES	NO	TYPE/FREQ/DUR	WHO WILL PROVIDE AGENCY/FAMILY	AGENCY FREQUENCY
A. Bathing					
Dressing					
Toileting					
Admin. Med.					
Grooming					
Spoon feeding					
Exercise/activity/walking					
Shopping (food/supplies)					
Meal preparation					
Diet Counseling					
Light housekeeping					
Personal laundry/household linens					
Personal/financial errands					
Other					
B. Nursing					
Physical Therapy					
Home Health Aide					
Speech Pathology					
Occupational Therapy					
Personal Care					
Homemaking					
Housekeeping					
Clinic/Physician					
Other 1.					
2.					
C. Ramps outside/inside					
Grab bars/hallways/bathroom					
Commode/special bed/wheelchair					
Cane/walker/crutches					
Self-help device, specify					
Dressings/cath. equipment, etc.					
Bed protector/diapers					
Other					
D. Additional Services (Lab, O^2, medication)					
Telephone reassurance					
Diversion/friendly visitor					
Medical social service/counseling					
Legal/protective services					
Financial management/conservatorship					
Transportation arrangements					
Transportation attendant					
Home delivered meals					
Structural modification					
Other					

15. To be completed by S S W and R.N

DMS Predictor Score _____ Override necessary ☐ Yes ☐ No

Can patient's health/safety needs be met through home care now? ☐ Yes ☐ No

If no, give specific reason why not _____

Institutional care required now? ☐ Yes ☐ No If yes, give specific reason why.

Level of institutional care determined by your professional judgment: ☐ SNF ☐ HRF ☐ DCF

Can the patient be considered at a later time for home care? ☐ Yes ☐ No ☐ N/A

16. To be completed by S S W
SUMMARY OF SERVICE REQUIREMENTS
Indicate services required, schedule and charges (allowable charge in area)

Services	Provided by	Hrs./Days/Wk.	Date Effective	Est. Dur.	Unit Cost	Payment by			
						MC	MA	Self	Other
Physician									
Nursing									
Home Health Aide									
Physical Therapy									
Speech Pathology									
Resp. Therapy									
Med. Soc. Work									
Nutritional									
Personal Care									
Homemaking									
Housekeeping									
Other (Specify)									
Medical Supplies/Medication 1.									
2.									
3.									
Medical Equipment 1.									
2.									
3.									
Home Delivered Meals									
Transportation									
Additional Services 1.									
2.									
			SUBTOTAL						
Structural Modification									
Other (Specify) 1.									
2.									

SUBTOTAL _____

TOTAL COST _____

17. To be completed by S S W and R.N.

Person who will relieve in case of emergency

Name	Address	Telephone	Relationship

Narrative: Use this space to describe aspects of the patients care not adequately covered above.

Assessment completed by:

R.N.	Agency
Date Completed	Telephone No.
Local DSS Staff	District
Date Completed	Telephone No.
Supervisor DSS	District
Date	Telephone No.

Authorization to provide services:

Local DSS Commissioner or Designee — Date

HOME ASSESSMENT ABSTRACT
FOR THE PERSONAL CARE SERVICES PROGRAM
Instructions

Purpose:

The purpose of the Home Assessment Abstract is to assist in the determination of whether a patient's home environment is the appropriate setting for the patient to receive health and related services. This form is designed to provide a standardized method for all certified home health agencies and social services districts to determine the following questions essential to the delivery of home care services:

1. Is the home the appropriate environment for this patient's needs?

2. What is the functional ability of this patient?

3. What services are necessary to maintain this patient within this home setting?

General Information:

The assessment form includes an outline for the planning for the development of a comprehensive listing of services which the patient requires.

It is required that a common assessment procedure be used for the Long Term Home Health Care Program (LTHHCP), Home Health Aide Services and Personal Care Services. This procedure will apply to both initial assessments and reassessments. The Home Assessment Abstract must be used in conjunction with the physician's orders and the DMS-1 or its successor.

The assessment procedure will differ only in the frequency with which assessments are required. Assessments must be completed at the initial onset of care. Reassessments are required every 120 days for the LTHHCP and Home Health Aide Services. Reassessments for Personal Care Services are required on an as-needed basis, but must be done at least every six (6) months. At any time that a change in the condition of the patient is noted either by staff of the certified home health agency or the local social services district, that agency should immediately inform the other agency so that the procedures for reassessment can be followed.

The form has been designed so that certified home health agencies and local social services districts may complete assessments jointly, a practice which is highly recommended. When it is not possible to undertake assessments jointly, an indication of the person responsible for completing each section has been included on the form. If, while completing the assessment, a nurse or a social services worker believes they have information in one of the other areas of the form, for which they are not responsible, they may include that information.

It is required that the local certified home health agency complete the assessment form within fifteen (15) working days of the request from the local social services district. Completed forms should be forwarded to the local social services district. Differences in opinion on the services required should be forwarded to the local Professional Director, for review and final determination by a physician.

Instructions:

Section 1 – Reasons for Preparation (RN and SSW)

Check appropriate box depending on whether patient is being considered for admission to a LTHHCP, home health aide service provided by a certified home health agency, or personal care services.

For reassessment, include the dates covered by the reassessment and check whether the reassessment is for a LTHHCP patient, certified home health agency patient, or personal care service patient. If none is appropriate, specific under "other" why form is being completed.

Section 2 – Patient Identification (RN and SSW)

Complete patient's name and place of residence. If the patient is or will be residing at a place other than his home address, give the address where he will be receiving care. Include directions to address where the patient will be receiving care.

The item "Social Services District" requires the name of the Social Services District which is legally responsible for the cost of the care. In large Social Services districts the number or name of the field office should be indicated.

Section 3 – Current Location of patient (RN and SSW)

Check the current location/diagnosis of the patient. If the patient is in an institution, give name of facility. If he/she is at home and receiving home care, give name of organization providing the service. Complete the "Diagnosis" on all cases.

Section 4 – Next of Kin/Guardian (SSW)

Complete this section with the name of the person who is legally responsible for the patient. This may be a relative or a non-relative who has been designated as power of attorney, conservator or committee for the management of the patient's financial affairs.

Section 5 – Notify in Emergency (SSW)

Complete section with requested information on whom to call in an emergency situation.

Section 6 – Patient Information (SSW)

Complete all information pertinent to the patient. Use N/A if an item is not applicable. Specify the language(s) that the patient speaks and understands.

Check the category of living arrangements that best describes the living arrangements of the patient.

Definitions of Living Arrangements:

One family house – nuclear and extended family

Multi-family house – tow or more distinct nuclear families

Furnished room – one room in a private dwelling, with or without cooking facilities

Senior citizen housing – apartments, either in clusters or high-rise

Hotel – a multi-dwelling providing lodging and with or without meals

Apartment – a room(s) with housekeeping facilities and used as a dwelling by a family group or an individual

Boarding House – a lodging house where meals are provided

If walk-up – when the living unit requires walking up stairs, specify number of flights

Lives with – specify with whom the patient lives. Members of household should be detailed in Section 7.

Other Patient Information:

Social Security Number	To obtain correct numbers, the interviewer should ask to see the patient's identification care for each item.
Medicare Numbers	
Medicaid Number	
Blue Cross Number	
Worker's Compensation	
Veterans Claim Number	

Veterans Spouse – patient may be eligible for benefits if a veteran's spouse.

Other – Identify insurance company and claim number if the patient has coverage in addition to those listed above.

Source of Income/other benefits – Include all sources of income and benefits. When the patient is receiving Medicaid or if Medicaid is pending, the local social services district will already have all necessary information.

Amount of available funds – Since many elderly people have little money left after payment of rent, taxes and utilities, an effort should be made to determine the amount available after payment of these expenses. This is especially important in evaluating whether or not the patient has adequate funds for food and clothing.

Section 7 – Others in Home/Household (SSW)

Indicate all persons residing in the house with the patient and indicate if and when they will assist in the care of the patient. Indicate in Section 14 what service this person(s) will provide. This information must be specific as it will be used to prepare a summary of service requirements for the individual patient.

Section 8 – Significant others Outside of Home – (SSW)

A "Significant Other" is an individual who has an interest in the welfare of the patient and may influence the patient. This may be a relative, friend, or neighbor who may be able to provide some assistance in rendering care. Indicate the days/hours that this person will provide assistance.

Section 9 – community Support – (SSW)

Indicate organizations, agencies or employed individuals, including local social services districts or certified home health agencies who have, or who are presently giving service to the patient; also indicate those services that have been provided in the past six months. Agencies providing home care, home delivered meals, or other services should be included if they have been significant to the care of the patient.

Section 10 – Patient traits – (SSW and RN)

Patient traits should help to determine the degree of independence a patient has and how this will affect care to this patient in the home environment. A patient's safety may be jeopardized if he shows emotional or psychological disturbance or confusion. It is important to determine if the patient is motivated to remain at home, otherwise services provided may not be beneficial.

For all criteria check the "yes" column if the patient meets the standard of the criteria defined. If, in your judgment the patient does not meet the standard as defined, check "no". If you have insufficient evidence to make a positive or negative statement about the patient, check the box marked "?/NA" – unknown or not applicable. If you check a no or ?/NA, please explain the reason in the space to the right. Also indicate source of information used as basis for your judgment.

Definitions:

Appears self directed and/or independent – the patient can manage his own business affairs, household needs, etc., either directly or through instruction to others.

Seems to make appropriate decisions –n the patient is capable of making choices consistent with his needs, etc.

Can recall med. Routine/recent events – the patient's memory is intact, and patient remembers when to take medication without supervision or assistance. Patient knows medical regimen.

Participates in planning/treatment program – the patient takes an active role in decision-making.

Seems to handle crisis well – this means that the patient knows whom to call and what to do in the event of an emergency situation.

Accepts Diagnoses – the patient knows his diagnoses and has a realistic attitude toward his illness

Motivated to remain at home – the patient wants to remain in his home to receive needed care.

Section 11 – Family Traits (SSW and RN as appropriate)

This section should be used to indicate whether the family is willing and/or able to care for the patient at home. The family may be able to care for the patient if support services are provided, and if required instruction and supervision are given, as appropriate, to the patient and/or family.

Definitions:

a. Is motivated to keep patient home – this means that the family member(s) is (are) willing to have the patient stay at home to receive the needed care and will provide continuity of care in those intervals when there is no agency person in the home by providing care themselves or arranging for other caretakers.

b. Is capable of providing care – the family member(s) is (are) physically and emotionally capable of providing care to the patient in the absence of caretaker personnel, and can accept the responsibility for the patient's care.

c. Will keep patient home if not involved with care – the family member(s) will allow the patient space in the home but will not (or cannot) accept responsibility for providing the necessary services in the absence of Home Care Services.

d. Will give care if support services given – this means that the family member(s) will accept responsibility for and provide care to the patient as long as some assistance from support personnel is given to the family member(s).
e. Requires instruction to provide care – this item means that the family is willing and able to keep the patient at home and provide care but will need guidance and teaching in the skills to provide care safely and adequately.

Section 12 – Home/Place where care will be provided – (RN)

In order to care for a person in the home, it is necessary to have an environment which provides adequate supports for the health and safety of the patient. This section of the assessment is to determine if the home environment of the patient is adequate in relation to the patient's physical condition and diagnosis. Input from the patient and family should be considered where pertinent.

Specifically describe the problem if one exists.

Definitions:

Neighborhood secure/safe – refers to how the patient and/or family perceives the neighborhood, for example, in the assessor's perception, the neighborhood may not be safe or secure but the patient may feel comfortable and safe.

Housing adequate in terms of space – refers to the available space that the patient will be able to have in the home. The space should be in keeping with the patient's home health care needs, without encroaching on other members of the family.

Convenient toilet facilities – refers to the accessibility and availability of toilet facilities in relation to the patient's present infirmities.

Heating adequate and safe – refers to the type of heating that will produce a comfortable environment. Safety and accessibility factors should be considered.

Laundry facilities – refers to appliances that are available and accessible to the patient and/or family.

Cooking facilities and refrigerator – refers to those appliances that are available and accessible for use by the patient or family.

Tub/shower/hot water – refers to what bathing facilities are available and if the patient is able to use what is available. Modifications may have to be made to make the facilities accessible to the patient.

Elevator – refers to the availability of a working elevator and if the patient is able to use it.

Telephone accessible and usable – refers to whether or not there is a telephone in the home, or if one is available. Specify whether or not the patient is able to reach and use the telephone.

Is patient mobile in house – refers to the ability of the patient to move about in the home setting. Modifications may have to be made to allow mobility, for example, widening doorways and adding ramps for a patient in a wheelchair.

Any discernible hazards – refers to any hazard that could possibly have a negative impact on the patient's health and safety in the home.

Construction adequate – refers to whether or not the building is safe for habitation.

Excess use of alcohol/drugs by patient or caretaker – refers to whether or not the patient or caretaker uses those materials enough to endanger the patient's health and safety because of inadequate judgment, poor reaction time, etc.; smokes carelessly.

Is patient's safety threatened if alone – refers to situations that may cause injury to the patient. This includes situations such as physical incapacitation, impaired judgment to the point where the patient will allow anyone to enter the home, wandering away from home, and possibility of the patient causing harm to himself or others.

Pets – refers to if the patient has a pet(s) and if so, what problems does it present, for example, is the patient able to take care of the pet, is the pet likely to endanger the patient's caretaker, and what plans, if any, must be made for the care of the animal.

Additional Assessment factors – include items that would influence the patient's ability to receive care at home that are not considered previously.

Section 13 – Recovery Potential (RN)

The anticipated recovery potential is important for short and long range planning.

Full recovery – the patient is expected to regain his optimal state of health.

Recovery with patient managed residual – the patient is expected to recover to his fullest potential with residual problem managed by himself, e.g., a diabetic who self-administers insulin and controls his diet.

Limited recovery managed by others – the patient is expected to be left with a residual problem that necessitates the assistance of another in performing activities of daily living.

Deterioration – it is expected that the patient's condition will decline with no likelihood of recovery.

Section 14 – Services Required (RN, SSW to complete "D" as appropriate)

This section will serve as the basis for the authorization for service delivery. Fill in all services required, describing type, frequency and duration as pertinent. Specify whether the family or an agency will be providing services and frequency that the agency will be involved. It is necessary to determine the amount of services required to enable the local Social Services district to develop the summary of service requirements and to arrive at a total cost necessary to the Long Term Home Health Care Program. The local Social Services district will make the final budgetary determinations.

A. This section determines that activities the patient can/cannot do for himself, also the frequency which the patient needs help in performing these activities.

B. The RN should determine what level of services are needed or anticipated.

Example:

	Yes	No	Type/Freq. Dur.	Agency/Family Agency Freq.
Registered Nurse	X		1 hr.2xWk/1 mo.	V.N.S.
Physical Therapy		X		
Home Health Aide	X		4 hr/3xWk/ 1mo.	V.N.S.
Speech Pathology		X		
Occupational Therapy		X		
Personal Care	X		4 hr./5xWk/1 mo.	Homemaker Upjohn
Clinic	X		1xWk-Mondays 1 pm	

C. Equipment/Supplies

The nurse should determine what medical supplies and equipment are necessary to assist the patient. Consideration should be for the rehabilitation and safety needs of the patient. Circle the specific equipment required and described in type/freq./dur. column, etc.

Example:

Dressing, cath equipment----#18 Foley/1xmo/6mo

D. Other Services

The RN should indicate any other health service needed for the total care of the patient. The SSW should complete the balance of the service needs.

Service needs will not be changed by the local social services district without consulting with the nurse. If there is disagreement, the case will be referred to the local professional director for review and final determination by a physician.

Section 15 – (SSW and RN)

DMS-1 Predictor Score

The predictor score must be completed. To be eligible for the LTHHCP, the patient's level of care needs must be determined and must be at the Skilled Nursing Facility (SNF) or Health Related Facility (HRF) level. The predictor score must be completed for home health aide and personal care services to assure adequate information for placement of personnel.

If the patient is institutionalized the predictor score should be obtained from the most recent DMS-1 completed by the discharge planner of that facility. If the patient is at home, it may be necessary for the nurse from the LTHHCP or certified home health agency to complete a DMS-1 form during the home assessment to ascertain the predictor score. Refer to the instructions for completing the DSM-1, if necessary.

Override necessary

An override is necessary when a patient's predictor score does not reflect the patient's true level of care. For example, a patient with a low predictor score may require institutional care due to emotional instability or safety factors. Either the institution's Utilization Review physician or physician representing the local professional director must give the override.

Can needs be met through home care?

Indicate if the patient can remain at home if appropriate services are provided. If the patient should not remain at home for health or safety reasons, be specific in your reply.

Institutional Care

Give specific reason why institutionalization is required. Check the level of institutional care the patient requires. Indicate if the patient can be considered for home care in the future.

Section 16 – Summary of Service Requirements – (SSW)

This information is to be used in correlation with services required for the patient to remain at home (Section 14). This section is to determine the cost of each individual service, source of payment, data services are effective and total monthly budget.

The SSW should complete this section including unit cost and source of payment. Subtotal and total costs will be determined by the local social services department.

Section 17 – Person who will relieve in an emergency – (SSW and RN)

This should be an individual who would be available to stay with the patient, if required, in a situation where the usual, planned services are not available. An example would be, when an aide did not appear on schedule, and the patient could not be left alone.

Narrative – (SSW and RN)

The narrative should be used to describe details of the patient's condition, not covered in previous sections, that will influence the decision regarding placement of the patient.

Assessment completed by

Each professional should sign and date this form. Include agency and telephone number.

Authorization to provide services for the LTHHCP, Home Health Aide or Personal Care Services will be provided by the Local District Social Services Commissioner or his designee.

NEW YORK STATE HEALTH DEPARTMENT NUMERICAL STANDARDS MASTER SHEET
NUMERICAL STANDARDS FOR APPLICATION FOR THE LONG TERM CARE PLACEMENT FORM
MEDICAL ASSESSMENT ABSTRACT
(DMS-1)

3.a.

Nursing Care and Therapy (Specify details in 3d, 3e or attachment)	Frequency			Self Care		Can Be Trained	
	None	Day Shift	Night/Eve. Shift	Yes	No	Yes	No
Parenteral Meds	0	25	60	-15	0	0	0
Inhalation Treatment	0	38	37	-20	0	0	0
Oxygen	0	49	49	-4	0	0	0
Suctioning	0	50	50	-1	0	0	0
Aseptic Dressing	0	42	48	0	0	+1	0
Lesion Irrigation	0	49	49	-20	0	0	0
Cath/Tube Irrigation	0	35	60	-1	0	+4	0
Ostomy Care							
Parenteral Fluids	0	50	50				
Tube Feedings	0	50	50				
Bowel/Bladder Rehab.	0	48	48				
Bedsore Treatment	0	50	50				
Other (Describe)	0	0	0				

b.
Incontinent

Urine: Often* [ ] 20 Seldom** [ ] 10 Never [ ] 0 Foley [ ] 15
Stool: Often* [ ] 40 Seldom** [ ] 20 Never [ ] 0

c.
Does patient need a special diet? No [ ] Yes [ ]

If yes, describe_____

4.

Function Status	Self Care	Some Help	Total Help	Cannot
Walks with or w/o aids	0	35	70	105
Transferring	0	6	12	18
Wheeling	0	1	2	3
Eating/Feeding	0	25	50	
Tolieting	0	7	14	
Bathing	0	17	24	
Dressing	0	40	80	

5.

Mental Status	Never	Sometimes	Always
Alert	40	20	0
Impaired Judgement	0	15	30
Agitated (nightime)	0	10	20
Hallucinates	0	1	2
Severe Depression			*
Assaultive	0	40	80
Abusive	0	25	50
Restraint Order	0	40	80
Regressive Behavior	0	30	60
Wanders			
Other (Specify)			

6.

Impairments	None	Partial	Total
Sight	0	1	2
Hearing	0	1	2
Speech	0	10	20
Communications			
Other (Contractures, etc.)			

7.

Short Term Rehab. Therapy Plan (To be completed by Therapist)

a.	Describe Condition (not Dx) Needing Intervention	Short Term Plan of Treatment & Eval. and Progress in last 2 weeks	Achievement Date

b. Circle Minimum number of days/week of skilled therapy from each of the following:

REQUIRES		RECEIVES
0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	SPEECH	0 1 2 3 4 5 6 7

+ 37 for skilled rehab/therapy (received & required both>0)