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Patient _____ Identifier _____ Date _____

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 5.00

PATIENT ASSESSMENT FORM - UNPLANNED DISCHARGE

Section A Administrative Information

A0050. Type of Record

Enter Code

1. **Add new assessment/record**
2. **Modify existing record**
3. **Inactivate existing record**

A0100. Facility Provider Numbers. Enter Code in boxes provided.

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Medicaid Provider Number:

A0200. Type of Provider

Enter Code

3. **Long-Term Care Hospital**

A0210. Assessment Reference Date

Observation end date:

_ _

Month Day Year

A0220. Admission Date

_ _

Month Day Year

A0250. Reason for Assessment

Enter Code

01. **Admission**
10. **Planned discharge**
11. **Unplanned discharge**
12. **Expired**

A0270. Discharge Date

_ _

Month Day Year

Section A Administrative Information

Patient Demographic Information

A0500. Legal Name of Patient

A. First name:

B. Middle initial:

C. Last name:

D. Suffix:

A0600. Social Security and Medicare Numbers

A. Social Security Number:

_ _

B. Medicare number (or comparable railroad insurance number)**:**

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

A0800. Gender

Enter Code

1. **Male**
2. **Female**

A0900. Birth Date

_ _

Month Day Year

Section A Administrative Information

A1400. Payer Information

Check all that apply

☐	**A. Medicare** (traditional fee-for-service)
☐	**B. Medicare** (managed care/Part C/Medicare Advantage)
☐	**C. Medicaid** (traditional fee-for-service)
☐	**D. Medicaid** (managed care)
☐	**E. Workers' compensation**
☐	**F. Title programs** (e.g., Title III, V, or XX)
☐	**G. Other government** (e.g., TRICARE, VA, etc.)
☐	**H. Private insurance/Medigap**
☐	**I. Private managed care**
☐	**J. Self-pay**
☐	**K. No payer source**
☐	**X. Unknown**
☐	**Y. Other**

A1990. Patient Discharged Against Medical Advice?

Enter Code

0. **No**
1. **Yes**

A2105. Discharge Location

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing bed)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not Listed**

Section A Administrative Information

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

At the time of discharge to another provider, did your facility provide the patient's current reconciled medication list to the subsequent provider?

Enter Code	
	0. **No** – Current reconciled medication list not provided to the subsequent provider → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge* 1. **Yes** – Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	Check all that apply ↓
A. Electronic Health Record	☐
B. Health Information Exchange	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

A2123. Provision of Current Reconciled Medication List to Patient at Discharge

At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?

Enter Code	
	0. **No** – Current reconciled medication list not provided to the patient, family and/or caregiver → *Skip to C1310, Signs and Symptoms of Delirium (from CAM©)* 1. **Yes** – Current reconciled medication list provided to the patient, family and/or caregiver

A2124. Route of Current Reconciled Medication List Transmission to Patient

Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.

Route of Transmission	Check all that apply ↓
A. Electronic Health Record (e.g., electronic access to patient portal)	☐
B. Health Information Exchange	☐
C. Verbal (e.g., in-person, telephone, video conferencing)	☐
D. Paper-based (e.g., fax, copies, printouts)	☐
E. Other Methods (e.g., texting, email, CDs)	☐

Section C Cognitive Patterns

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after** reviewing medical record.

A. Acute Onset Mental Status Change

Enter Code

Is there evidence of an acute change in mental status from the patient's baseline?

0. **No**
1. **Yes**

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Code in Boxes**

B. Inattention - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?

C. Disorganized thinking - Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria?

- **vigilant -** startled easily to any sound or touch
- **lethargic -** repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous -** very difficult to arouse and keep aroused for the interview
- **comatose -** could not be aroused

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

Section J Health Conditions

J1800. Any Falls Since Admission

Enter Code

Has the patient **had any falls since admission?**

0. **No** → *Skip to K0520, Nutritional Approaches*
1. **Yes** → *Continue to J1900, Number of Falls Since Admission*

J1900. Number of Falls Since Admission

Coding:
0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

	A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.
	B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain.
	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Section K Swallowing/Nutritional Status

K0520. Nutritional Approaches

4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days **5. At Discharge** Check all of the nutritional approaches that were being received at discharge	**4. Last 7 Days** **Check all that apply** ↓	**5. At Discharge** **Check all that apply** ↓
A. Parenteral/IV feeding	☐	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. None of the above	☐	☐

Section M Skin Conditions

Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage.

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code

Does this patient have one or more unhealed pressure ulcers/injuries?

0. **No** → *Skip to N0415, High-Risk Drug Classes: Use and Indication*
1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

1. **Number of Stage 1 pressure injuries**

Enter Number

Enter Number

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.

1. **Number of Stage 2 pressure ulcers -** If 0 → *Skip to M0300C, Stage 3*

2. **Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number

Enter Number

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

1. **Number of Stage 3 pressure ulcers** - If 0 → *Skip to M0300D, Stage 4*

2. **Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number

Enter Number

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

1. **Number of Stage 4 pressure ulcers** - If 0 → *Skip to M0300E, Unstageable - Non-removable dressing/device*

2. **Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

Enter Number

Enter Number

1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - If 0 → *Skip to M0300F, Unstageable - Slough and/or eschar*

2. **Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission** - enter how many were noted at the time of admission

Enter Number

Enter Number

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → *Skip to M0300G, Unstageable - Deep tissue injury*

2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission

Enter Number

Enter Number

G. Unstageable - Deep tissue injury

1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → *Skip to N0415, High-Risk Drug Classes: Use and Indication*

2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission** - enter how many were noted at the time of admission

Section N Medications

N0415. High-Risk Drug Classes: Use and Indication

1. Is taking Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes **2. Indication noted** If column 1 is checked, check if there is an indication noted for all medications in the drug class	**1. Is taking** **Check all that apply** ↓	**2. Indication noted** **Check all that apply** ↓
A. Antipsychotic	☐	☐
E. Anticoagulant	☐	☐
F. Antibiotic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
Z. None of the above	☐	

N2005. Medication Intervention

Enter Code ☐

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

0. **No**
1. **Yes**
9. **Not applicable - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications**

Section O Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that apply at discharge.

	c. At Discharge Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	☐
A2. IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-Invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐
Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Midline	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the Above	
Z1. None of the above	☐

Section O Special Treatments, Procedures, and Programs

O0200. Ventilator Liberation Rate (Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge)

Enter Code

A. Invasive Mechanical Ventilator: Liberation Status at Discharge

0. **Not fully liberated at discharge** (i.e., patient required partial or full invasive mechanical ventilation support within 2 calendar days prior to discharge)
1. **Fully liberated at discharge** (i.e., patient did not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge)
9. **Not applicable** (code only if the patient was not on invasive mechanical ventilator support upon admission [O0150A = 0] or the patient was determined to be non-weaning upon admission [O0150A2 = 0])

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that submitting false information may subject my organization to a 2% reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Assessment Completion

A. Signature:

B. LTCH CARE Data Set Completion Date:

__ __

Month Day Year