Patient _____ Identifier _____ Date _____

# LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 3.00

## PATIENT ASSESSMENT FORM - ADMISSION

## 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**

# 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

### A1000. Race/Ethnicity

**Check all that apply**

- ☐ **A. American Indian or Alaska Native**
- ☐ **B. Asian**
- ☐ **C. Black or African American**
- ☐ **D. Hispanic or Latino**
- ☐ **E. Native Hawaiian or Other Pacific Islander**
- ☐ **F. White**

# Section A Administrative Information

## A1100. Language

Enter Code ☐

**A. Does the patient need or want an interpreter to communicate with a doctor or health care staff?**

0. **No** → *Skip to A1200. Marital Status*
1. **Yes** → *Specify in A1100B. Preferred language*
9. **Unable to determine** → *Skip to A1200. Marital Status*

**B. Preferred language:**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

## A1200. Marital Status

Enter Code ☐

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

## 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 payor source** |
| ☐ | **X. Unknown** |
| ☐ | **Y. Other** |

## Pre-Admission Service Use

**A1802. Admitted From.** Immediately preceding this admission, where was the patient?

Enter Code ☐☐

01. **Community residential setting** (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
02. **Long-term care facility**
03. **Skilled nursing facility** (SNF)
04. **Hospital emergency department**
05. **Short-stay acute hospital** (IPPS)
06. **Long-term care hospital** (LTCH)
07. **Inpatient rehabilitation facility or unit** (IRF)
08. **Psychiatric hospital or unit**
09. **ID/DD Facility**
10. **Hospice**
99. **None of the above**

## Section B Hearing, Speech, and Vision

### B0100. Comatose

Enter Code ☐

**Persistent vegetative state/no discernible consciousness**

0. **No** → *Continue to BB0700. Expression of Ideas and Wants*
1. **Yes** → *Skip to GG0100. Prior Functioning: Everyday Activities*

### BB0700. Expression of Ideas and Wants (3-day assessment period)

Enter Code ☐

**Expression of ideas and wants** (consider both verbal and non-verbal expression and excluding language barriers)

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand

### BB0800. Understanding Verbal Content (3-day assessment period)

Enter Code ☐

**Understanding Verbal Content** (with hearing aid or device, if used and excluding language barriers)

4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/Never Understands**

## Section C Cognitive Patterns

**C1610. Signs and Symptoms of Delirium (from CAM©)**
Confusion Assessment Method (CAM©) Shortened Version Worksheet (3-day assessment period)

**CODING:**
**0. No**
**1. Yes**

↓ **Enter Code in Boxes**

| | |
|---|---|
| ☐ | **Acute Onset and Fluctuating Course**<br>**A.** Is there evidence of an acute change in mental status from the patient's baseline? |
| ☐ | **B.** Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity? |
| ☐ | **Inattention**<br>**C.** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? |
| ☐ | **Disorganized Thinking**<br>**D.** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? |
| ☐ | **Altered Level of Consciousness**<br>**E.** Overall, how would you rate the patient's level of consciousness?<br>**E1**. Alert (Normal) |
| ☐ | **E2.** Vigilant (hyperalert) or Lethargic (drowsy, easily aroused) or Stupor (difficult to arouse) or Coma (unarousable) |

*Adapted with permission from: Inouye SK et al, Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Annals of Internal Medicine. 1990; 113: 941-948. Confusion Assessment Method: Training Manual and Coding Guide, Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.*

## Section GG Functional Abilities and Goals

**GG0100. Prior Functioning: Everyday Activities.** Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

3. **Independent** - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Patient needed partial assistance from another person to complete activities.
1. **Dependent** - A helper completed the activities for the patient.
8. **Unknown**
9. **Not Applicable**

↓ **Enter Codes in Boxes**

| | |
|---|---|
| ☐ | **B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury. |

**GG0110. Prior Device Use.** Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ **Check all that apply**

| | |
|---|---|
| ☐ | **A. Manual wheelchair** |
| ☐ | **B. Motorized wheelchair or scooter** |
| ☐ | **C. Mechanical lift** |
| ☐ | **Z. None of the above** |

**GG0130. Self-Care** (3-day assessment period)

**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).**

**CODING:**
**Safety** and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

**If activity was not attempted, code reason:**
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

| 1. Admission Performance | 2. Discharge Goal | |
|---|---|---|
| ↓ Enter Codes in Boxes ↓ | | |
| ☐☐ | ☐☐ | **A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. |
| ☐☐ | ☐☐ | **B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.] |
| ☐☐ | ☐☐ | **C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment. |
| ☐☐ | ☐☐ | **D. Wash upper body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed. |

## Section GG Functional Abilities and Goals

**GG0170. Mobility** (3-day assessment period)

**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).**

**CODING:**
**Safety** and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

**If activity was not attempted, code reason:**
07. **Patient refused**
09. **Not applicable**
88. Not attempted due to **medical condition or safety concerns**

| 1. Admission Performance | 2. Discharge Goal | |
|---|---|---|
| ↓ Enter Codes in Boxes ↓ | | |
| ☐☐ | ☐☐ | **A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back. |
| ☐☐ | ☐☐ | **B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed. |
| ☐☐ | ☐☐ | **C. Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. |
| ☐☐ | ☐☐ | **D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed. |
| ☐☐ | ☐☐ | **E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair). |
| ☐☐ | ☐☐ | **F. Toilet transfer:** The ability to safely get on and off a toilet or commode. |
| | | ☐ **H1. Does the patient walk?**<br>**0. No,** and walking goal **is not** clinically indicated → *Skip to GG0170Q1. Does the patient use a wheelchair/scooter?*<br>**1. No,** and walking goal **is** clinically indicated → *Code the patient's Discharge Goal(s) for items GG0170I, J, and K. For Admission Performance, skip to GG0170Q1. Does the patient use a wheelchair/scooter?*<br>**2. Yes** → *Continue to GG0170I. Walk 10 feet* |
| ☐☐ | ☐☐ | **I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space. |
| ☐☐ | ☐☐ | **J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns. |
| ☐☐ | ☐☐ | **K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space. |
| | | ☐ **Q1. Does the patient use a wheelchair/scooter?**<br>**0. No** → *Skip to H0350. Bladder Continence*<br>**1. Yes** → *Continue to GG0170R. Wheel 50 feet with two turns* |
| ☐☐ | ☐☐ | **R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. |
| | | ☐ **RR1. Indicate the type of wheelchair/scooter used.**<br>**1. Manual**<br>**2. Motorized** |
| ☐☐ | ☐☐ | **S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. |
| | | ☐ **SS1. Indicate the type of wheelchair/scooter used.**<br>**1. Manual**<br>**2. Motorized** |

## Section H Bladder and Bowel

**H0350. Bladder Continence (**3-day assessment period)

Enter Code ☐

**Bladder continence -** Select the one category that best describes the patient.

0. **Always continent** (no documented incontinence)
1. **Stress incontinence only**
2. **Incontinent less than daily** (e.g., once or twice during the 3-day assessment period)
3. **Incontinent daily** (at least once a day)
4. **Always incontinent**
5. **No urine output** (e.g., renal failure)
9. **Not applicable** (e.g., indwelling catheter)

**H0400. Bowel Continence** (3-day assessment period)

Enter Code ☐

**Bowel continence -** Select the one category that best describes the patient.

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** patient had an ostomy or did not have a bowel movement for the entire 3 days

## Section I Active Diagnoses

**I0050. Indicate the patient's primary medical condition category.**

Enter Code ☐

**Indicate the patient's primary medical condition category.**
1. **Acute onset respiratory condition** (e.g., aspiration and specified bacterial pneumonias)
2. **Chronic respiratory condition** (e.g., chronic obstructive pulmonary disease)
3. **Acute onset and chronic respiratory conditions**
4. **Chronic cardiac condition** (e.g., heart failure)
5. **Other medical condition** If "other medical condition", enter the ICD code in the boxes.

**I0050A.** ☐☐☐☐☐☐☐☐

**Comorbidities and Co-existing Conditions**

↓ **Check all that apply**

| | |
|---|---|
| **Cancers** | |
| ☐ | **I0101. Severe and Metastatic Cancers** |
| **Heart/Circulation** | |
| ☐ | **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)** |
| **Genitourinary** | |
| ☐ | **I1501. Chronic Kidney Disease, Stage 5** |
| ☐ | **I1502. Acute Renal Failure** |
| **Infections** | |
| ☐ | **I2101. Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock** |
| ☐ | **I2600. Central Nervous System Infections, Opportunistic Infections, Bone/Joint/Muscle Infections/Necrosis** |
| **Metabolic** | |
| ☐ | **I2900. Diabetes Mellitus (DM)** |
| **Musculoskeletal** | |
| ☐ | **I4100. Major Lower Limb Amputation** (e.g., above knee, below knee) |
| **Neurological** | |
| ☐ | **I4501. Stroke** |
| ☐ | **I4801. Dementia** |
| ☐ | **I4900. Hemiplegia or Hemiparesis** |
| ☐ | **I5000. Paraplegia** |
| ☐ | **I5101. Complete Tetraplegia** |
| ☐ | **I5102. Incomplete Tetraplegia** |
| ☐ | **I5110. Other Spinal Cord Disorder/Injury** (e.g., myelitis, cauda equina syndrome) |
| ☐ | **I5200. Multiple Sclerosis (MS)** |
| ☐ | **I5250. Huntington's Disease** |
| ☐ | **I5300. Parkinson's Disease** |
| ☐ | **I5450. Amyotrophic Lateral Sclerosis** |
| ☐ | **I5460. Locked-In State** |
| ☐ | **I5470. Severe Anoxic Brain Damage, Cerebral Edema, or Compression of Brain** |
| **Nutritional** | |
| ☐ | **I5601. Malnutrition** (protein or calorie) |
| ☐ | **I5602. At Risk for Malnutrition** |
| **None of the Above** | |
| ☐ | **I7900. None of the above** |

## Section K Swallowing/Nutritional Status

**K0200. Height and Weight -** While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

| | |
|---|---|
| ☐☐ inches | **A. Height** (in inches). Record most recent height measure since admission. |
| ☐☐☐ pounds | **B. Weight** (in pounds). Base weight on most recent measure in last 3 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off). |

## Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

### M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

**Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**

0. **No** → *Skip to O0100. Special Treatments, Procedures, and Programs*
1. **Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*

### M0300. Current Number of Unhealed Pressure Ulcers 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

**Number of Stage 1 pressure ulcers**

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**

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**

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**

Enter Number ☐

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

1. **Number of unstageable pressure ulcers due to non-removable dressing/device**

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**

Enter Number ☐

**G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution

1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**

## Section O Special Treatments, Procedures, and Programs

**O0100. Special Treatments, Procedures, and Programs**

Check all the treatments at admission. For dialysis, check if it is part of the patient's treatment plan.

| ↓ Check all that apply | |
|---|---|
| **Respiratory Treatments** | |
| ☐ | **F3. Invasive Mechanical Ventilator: weaning** |
| ☐ | **F4. Invasive Mechanical Ventilator: non-weaning** |
| ☐ | **G. Non-invasive Ventilator (BIPAP, CPAP)** |
| **Other Treatments** | |
| ☐ | **J. Dialysis** |
| ☐ | **N. Total Parenteral Nutrition** |
| **None of the Above** | |
| ☐ | **Z. None of the above** |

**O0250. Influenza Vaccine - Refer to current version of LTCH Quality Reporting Program Manual for current influenza season and reporting period.**

Enter Code ☐

**A.** Did the **patient receive the influenza vaccine <u>in this facility</u>** for this year's influenza <u>vaccination</u> season?

0. **No** → *Skip to O0250C. If influenza vaccine not received, state reason*
1. **Yes** → *Continue to O0250B. Date influenza vaccine received*

**B.** Date influenza vaccine received → *Complete date and skip to Z0400. Signature of Persons Completing the Assessment*

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

**C. If influenza vaccine not received, state reason:**

1. **Patient not in this facility during this year's influenza vaccination season**
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

# 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

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1163**. The time required to complete this information collection is estimated to average **30 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.