Patient _____ Identifier _____ Date _____

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

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

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

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**

A2110. Discharge Location

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**
12. **Discharged Against Medical Advice**
98. **Other**

Section A Administrative Information

A2500. Program Interruption(s)

Enter Code ☐

Program Interruptions

0. **No** → *Skip to C1610. Signs and Symptoms of Delirium (from CAM©)*
1. **Yes** → *Continue to A2510. Number of Program Interruptions During This Stay in This Facility*

A2510. Number of Program Interruptions During This Stay in This Facility

Enter Number ☐☐

Number of Program Interruptions During This Stay in This Facility. *Code only if A2500 is equal to 1.*

A2525. Program Interruption Dates. *Code only if A2510 is greater than or equal to 01.*

A1. First Interruption Start Date	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year
A2. First Interruption End Date	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year
B1. Second Interruption Start Date *Code only if A2510 is greater than 01.*	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year
B2. Second Interruption End Date *Code only if A2510 is greater than 01.*	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year
C1. Third Interruption Start Date *Code only if A2510 is greater than 02.*	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year
C2. Third Interruption End Date *Code only if A2510 is greater than 02.*	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year
D1. Fourth Interruption Start Date *Code only if A2510 is greater than 03.*	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year
D2. Fourth Interruption End Date *Code only if A2510 is greater than 03.*	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year
E1. Fifth Interruption Start Date *Code only if A2510 is greater than 04.*	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year
E2. Fifth Interruption End Date *Code only if A2510 is greater than 04.*	☐☐ – ☐☐ – ☐☐☐☐	Month Day Year

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** **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** **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** **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** **E.** Overall, how would you rate the patient's level of consciousness? **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 J. Health Conditions

J1800. Any Falls Since Admission

Enter Code ☐

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

0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)*
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 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 O0250. Influenza Vaccine*
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 ☐

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*

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

Enter Number ☐

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** - If 0 → *Skip to M0300F. Unstageable - Slough and/or eschar*

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 ☐

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

M0300 continued on next page

Section M Skin Conditions

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued

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** - If 0 → *Skip to M0800. Worsening in Pressure Ulcer Status Since Admission*

Enter Number ☐

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

M0800. Worsening in Pressure Ulcer Status Since Admission

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission.
If no current pressure ulcer at a given stage, enter 0

Enter Number	
☐	**A. Stage 2**
☐	**B. Stage 3**
☐	**C. Stage 4**
☐	**D. Unstageable - Non-removable dressing**
☐	**E. Unstageable - Slough and/or eschar**
☐	**F. Unstageable - Deep tissue injury**

Section O Special Treatments, Procedures, and Programs

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 in this facility** for this year's influenza vaccination 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.