

CARE Tool Item Matrix

Item Number	Item Description	Acute Hospital Discharge	PAC Admission	PAC Discharge	Interim	Expired
Attestation and Signatures of Persons who Completed a Portion of the Assessment						
	Signatures	C	C	C	C	C
I. Administrative Items						
<i>A. Assessment Type</i>						
A1	Reason for Assessment	C	C	C	C	C
A2	Admission Date	C	C	C	C	C
A3	Assessment Reference Date	C	C	C	C	C
A4	Expired Date					C
<i>B. Provider Information</i>						
B1	Provider's Name	C	C	C	C	C
B2	Medicare Provider's Identification Number	C	C	C	C	C
B3	National Provider Identification Code (NPI)	C	C	C	C	C
<i>C. Patient Information</i>						
C1	Patient's First Name	C	C	C	C	C
C2	Patient's Middle Initial or Name	C	C	C	C	C
C3	Patient's Last Name	C	C	C	C	C
C4	Patient's Nickname (optional)	C	C	C	C	C
C5	Patient's Medicare Health Insurance Number	C	C	C	C	C
C6	Patient's Medicaid Number	C	C	C	C	C
C7	Patient's Identification Number/Provider Account Number	C	C			
C8	Birth Date	C	C			
C9	Social Security Number (optional)	C	C			
C10	Gender	C	C			
C11a-C11g	Race/Ethnicity	C	C			
C12	Is English the patient's primary language?	C	C			
C12a	If English is not the patient's primary language, what is the patient's primary language?	C	C			
C12b	Does the patient want or need an interpreter (language or sign language) to communicate with a doctor or health care staff?	C	C			
<i>D. Payer Information</i>						
D1-D13	Current Payment Sources	C	C	C	C	
T.I.	How long did it take you to complete this section?					
II. Admission Information						
<i>A. Pre-admission Service Use</i>						
A1	Admission Date	C	C			
A2	Admitted From	C	C			
A3	Primary diagnosis in previous setting	C	C			
A4a-A4i	Other Services in past 2 months	C	C			
<i>B. Patient History Prior To This Current Illness, Exacerbation, or Injury</i>						
B1	Where did patient live	C	C			
B2	If in community, Zip Code of Prior Residence	C	C			
B3a-B3d	If in community, help used	C	C			
B3aa-B3ad	If in the community, who did the patient live with?	C	C			
B4a-B4f	Structural barriers	C	C			
B5a-B5e	Prior Functioning	C	C			
B6a-B6h	Mobility Devices	C	C			
B7	History of Falls	C	C			
T.II.	How long did it take you to complete this section?					
III. Current Medical Information/Clinicians						
<i>A. Primary Diagnosis</i>						
A1	Primary Diagnosis at Assessment	C	C	C	C	C
<i>B. Other Diagnoses, Comorbidities, and Complications</i>						
B1-B15	Other Comorbidities	C	C	C	C	C
B16	Is this list complete?	C	C	C	C	C
<i>C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions)</i>						
C1	Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?	C	C	C	C	C
C1a-C15a	Procedures	S	S	S	S	S

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C1b-C15b	Right	S	S	S	S	S
C1c-C15c	Left	S	S	S	S	S
C1d-C15d	Not applicable	S	S	S	S	S
C16	Is list complete?	S	S	S	S	S
<i>D. Major Treatments</i>						
D1a-D30a	Admitted/Discharged With	C	C	C	C	C
D1b-D30b	Used at Any Time During Stay	C	C	C	C	C
D9c	Specify reason for continuous monitoring	S	S	S	S	S
D11c	Specify most intensive frequency of suctioning during stay	S	S	S	S	S
D23c	Specify reason for 24-hour supervision	S	S	S	S	S
D30c	Other Major Treatments: Specify	S	S	S	S	S
<i>E. Medications</i>						
E1a-E30a	Medication Name	C	C	C	C	C
E1b-E30b	Dose	C	C	C	C	C
E1c-E30c	Route	C	C	C	C	C
E1d-E30d	Frequency	C	C	C	C	C
E1e-E30e	Planned Stop Date	C	C	C	C	C
E31	Is list complete?	C	C	C	C	C
<i>F. Allergies and Adverse Drug Reactions</i>						
F1	Any Known Allergies or Reactions?	C	C	C		
F1a-F8a	Allergy/Cause of Reaction	S	S	S		
F1b-F8b	Patient Reactions	S	S	S		
F9	Is the list complete?	S	S	S		
<i>G. Skin Integrity</i>						
G1	Pressure Ulcer Risk	C	C	C	C	
G2	Any Stage 2+ Pressure Ulcers?	C	C	C	C	
	Number present at assessment/ Number with onset during this service	S	S	S	S	
G2a-G2d	If Stage 2 :Number of Unhealed	S	S	S	S	
G3a	Longest length in any direction	S	S	S	S	
G3b	Width of SAME unhealed ulcer or eschar	S	S	S	S	
G3c	Date of measurement	S	S	S	S	
G4	If Stage 3 or 4, Tunneling	S	S	S	S	
G5	Any Major Wounds (excluding pressure ulcer)	C	C	C	C	
G5a-G5e	Number and Type of Major Wounds	S	S	S	S	
G6a-G6e	Turning surfaces not intact	C	C	C	C	
<i>H. Physiologic Factors</i>						
H1a-H23a, H30a	Date	C	C	C	C	
H1b-H22b, H24b-H29b, H31b-H42b	Value	C	C	C	C	
H1c-H42c	Check if NOT tested	C	C	C	C	
H1d-H4d	Estimated value	C	C	C	C	
H10d	Specify source and amount of supplemental O ₂	C	C	C	C	
H23d	Specify source and amount of supplemental O ₂	C	C	C	C	
T.III.	How long did it take you to complete this section?					
IV. Cognitive Status						
<i>A. Comatose</i>						
A1	Persistent vegetative state	C	C			
<i>B. Temporal Orientation and BIMS</i>						
B1a	Interview attempted	C	C			
B1b	Reason interview not attempted	S	S			
B2a	Ask patient: "Please tell me what year it is right now."	C				
B2b	Ask patient: "What month are we in right now?"	C				
B3a	Repetition of three words		C			
B3b.1.	Ask patient: "Please tell me what year it is right now."		C			
B3b.2.	Ask patient: "What month are we in right now?"		C			
B3b.3.	Ask patient: "What day of the week is today?"		C			
B3c.1.	Recalls "sock?"		C			
B3c.2.	Recalls "blue?"		C			
B3c.3.	Recalls "bed?"		C			
<i>C. Observational of Cognitive Status</i>						
C1a-C1f	Memory/Recall Ability	S	S			
<i>D. Confusion Assessment Method</i>						
D1	Inattention	S	S			
D2	Disorganized thinking	S	S			
D3	Altered level of consciousness/alertness	S	S			
D4	Psychomotor retardation	S	S			

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<i>E. Behavioral Signs and Symptoms</i>						
E1	Physical		C	C		
E2	Verbal		C	C		
E3	Other		C	C		
<i>F. Mood</i>						
F1	Interview attempted		C	C		
F2a-F2d	PHQ2		C	C		
F3	Feeling Sad		C	C		
<i>G. Pain</i>						
G1	Interview attempted?	C	C	C	C	
G2	Pain presence	C	C	C	C	
G3	Pain severity 0-10	S	S	S	S	
G4	Pain effect on function	S	S	S	S	
G5	Limited activities because of pain	S	S	S	S	
G6a-G6e	Observed Pain	S	S	S	S	
T.IV.	How long did it take you to complete this section?					
V. Impairments						
<i>A. Bladder and Bowel Management</i>						
A1	Any impairments?	C	C	C	C	
A2a-A2b	Use of external or indwelling device	S	S	S	S	
A3a-A3b	Frequency of incontinence	S	S	S	S	
A4a-A4b	Assistance managing bowel/bladder equipment	S	S	S	S	
A5a-A5b	Incontinent prior to the current illness	S	S	S	S	
<i>B. Swallowing</i>						
B1	Any impairments?	C	C	C	C	
B1a-B1g	Swallowing: signs and symptoms	S	S	S	S	
B2a-B2c	Swallowing: usual ability	S	S	S	S	
<i>C. Hearing, Vision, Communication, & Comprehension</i>						
C1	Any impairments?	C	C	C	C	
C1a	Understanding verbal content	S	S	S	S	
C1b	Expression of ideas and wants	S	S	S	S	
C1c	Ability to see in adequate light	S	S	S	S	
C1d	Ability to hear	S	S	S	S	
<i>D. Weight-bearing</i>						
D1	Any impairments?	C	C	C	C	
D1a-D1d	Weight-bearing upper and lower extremities	S	S	S	S	
<i>E. Grip Strength</i>						
E1	Any impairments?	C	C	C	C	
E1a-E1b	Grip strength right and left hands	S	S	S	S	
<i>F. Respiratory Status</i>						
F1	Any impairments?	C	C	C	C	
F1a-F1b	Respiratory Status	S	S	S	S	
<i>G. Endurance</i>						
G1	Any impairments?	C	C	C	C	
G1a	Mobility Endurance	S	S	S	S	
G1b	Sitting Endurance	S	S	S	S	
<i>H. Mobility Devices and Aids Needed</i>						
H1a-H1h	Indicate all mobility and aids needed	C	C	C	C	
T.V.	How long did it take you to complete this section?					
VI. Functional Status						
<i>A. Self Care</i>						
A1	Eating	C	C	C	C	
A2	Tube Feeding	C	C	C	C	
A3	Oral Hygiene	C	C	C	C	
A4	Toilet Hygiene	C	C	C	C	
A5	Upper Body Dressing	C	C	C	C	
A6	Lower Body dressing	C	C	C	C	
<i>B. Core Functional Mobility</i>						
B1	Lying to Sitting on Side of Bed	C	C	C	C	
B2	Sit to Stand	C	C	C	C	

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B3	Chair/Bed-to-Chair Transfer	C	C	C	C	
B4	Toilet Transfer	C	C	C	C	
B5	Mode of Mobility	C	C	C	C	
B5a	Longest distance patient can walk	C	C	C	C	
B5b	Longest distance patient can wheel	C	C	C	C	
<i>C. Supplemental Functional Ability: Code patient on all activities that the patient can participate in and which you can observe.</i>						
C1	Wash upper body	S	S	S	S	
C2	Shower/bathe self	S	S	S	S	
C3	Roll Left and Right	S	S	S	S	
C4	Sit to Lying	S	S	S	S	
C5	Picking up object	S	S	S	S	
C6	Putting on/taking off footwear	S	S	S	S	
C7	Mode of Mobility: Wheelchair?	S	S	S	S	
C7a	One Step (curb)	S	S	S	S	
C7b	Walk 50 feet with 2 turns	S	S	S	S	
C7c	12 steps-interior	S	S	S	S	
C7d	4 steps-exterior	S	S	S	S	
C7e	Walking 10 feet on uneven surfaces	S	S	S	S	
C7f	Car transfer	S	S	S	S	
C7g	Wheel short ramp	S	S	S	S	
C7h	Wheel long ramp	S	S	S	S	
C8	Telephone-answering	S	S	S	S	
C9	Telephone-Placing Call	S	S	S	S	
C10	Medication Management-Oral Medications	S	S	S	S	
C11	Medication Management-Inhalant/Mist Medications	S	S	S	S	
C12	Medication Management-Injectable Medications	S	S	S	S	
C13	Make light meal	S	S	S	S	
C14	Wipe down surface	S	S	S	S	
C15	Light shopping	S	S	S	S	
C16	Laundry	S	S	S	S	
C17	Use Public Transportation	S	S	S	S	
T.VI.	How long did it take you to complete this section?					
VII. Overall Plan of Care/Advance Care Directives						
<i>A. Overall Plan of Care/Advance Care Directives</i>						
	Documented agreed-upon care goals and expected dates of completion	C	C	C	C	
A1		C	C	C	C	
A2	Description of overall status	C	C	C	C	
A3	Documented care decisions	C	C	C	C	
T.VII.	How long did it take you to complete this section?					
VIII. Discharge Status						
<i>A. Discharge Information</i>						
A1	Discharge date	C		C		
A2	Attending Physician	C		C		
A3	Discharge location	C		C		
A4	Frequency of Assistance at Discharge	C	C*	C		
A5	Caregiver Availability	C		C		
A6	Willing Caregiver(s)	S	C*	S		
A7	Types of Caregiver(s)	S	C*	S		
<i>B. Caregiver Information</i>						
B1	Patient lives with	S		S		
<i>C. Support Needs/Caregiver Assistance</i>						
C1a-C1h	Patient needs this	S	C*	S		
C2a-C2g	Caregiver able	S	C*	S		
C3a-C3g	Caregiver needs training or other supportive services	S	C*	S		
C4a-C4g	Caregiver not likely to be able	S	C*	S		
C5a-C5g	Caregiver ability unclear	S	C*	S		
<i>D. Discharge Care Options</i>						
D1a-D1k	Deemed Appropriate by the Provider	C		C		
D2a-D2k	Bed/Services Available	C		C		
D3a-D3k	Refused by Patient/Family	C		C		
D4a-D4k	Not Covered by Insurance	C		C		
<i>E. Discharge Location Information</i>						
E1	Discharged with referral	C		C		
E2	Provider Name	S		S		
E3	Provider Type	S		S		
E4	Provider City	S		S		
E5	Provider State	S		S		

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E6	Medicare Provider Identification Number	S		S		
E7	Discharge delay	S		S		
E8	Reason for Discharge Delay	S		S		
E9	Patient requests that information not be shared	S		S		
T.IX.	How long did it take you to complete this section?					
IX. Medical Coding Information						
<i>A. Principal Diagnosis</i>						
A1	ICD-9 CM Code for Principal Diagnosis	C	C	C	C	C
A1a	Principal Diagnosis at Assessment	C	C	C	C	C
A2	ICD-9 CM Code for Principal Diagnosis if it was a V-code If principal diagnosis was a V-code was the primary	S	S	S	S	S
A2a	medical condition or injury being treated	S	S	S	S	S
<i>B. Other Diagnoses, Comorbidity, and Complications</i>						
B1a-B15a	ICD-9 CM Code	C	C	C	C	C
B1b-B15b	Diagnosis	C	C	C	C	C
B16	Is this list complete?	C	C	C	C	C
<i>C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions)</i>						
C1	One or more major procedure	C	C	C	C	C
C1a-C15a	ICD-9 CM Code	S	S	S	S	S
C1b-C15b	Procedure	S	S	S	S	S
C16	Is this list complete?	S	S	S	S	S
X. Other Useful Information						
A1	Other useful information about this patient	S	S	S	S	S
XI. Feedback						
A1	Notes	S	S	S	S	S

Notes: *These items are included in home health admission assessments.