APPENDIX B: Changes to LTCH CARE Data Set v.1.01 to v.2.00

LTCH CARE Data Set Affected	Section or Item Number	Change	Rationale
Admission, Planned Discharge, Unplanned Discharge, and Expired	Multiple	Version number has changed from v1.01 to v2.00 on all pages Word "DRAFT" has been added to all pages Replaced "May 2012" with "Effective January 1, 2014"	To ensure information is accurate and versions are tracked.
Admission, Planned Discharge, Unplanned Discharge, and Expired	Item A0200	Revise Long-term Care Hospital to "Long-Term Care Hospital"	To ensure harmonizing of setting name across CMS documents for LTCH Quality Reporting Program.
Admission	Item A1802	Item number changed from A1800 to A1802	To ensure item number is accurate.
Planned Discharge and Unplanned Discharge	Item A2110	Item number changed from A2100 to A2110	To ensure item number is accurate.
Planned Discharge and Unplanned Discharge	Item A2500	Add item A2500: Program Interruption(s) 0. No → *Skip to M0210, Unhealed Pressure Ulcers* 1. Yes → *Continue to A2510, Number of Program Interruptions During This Stay in This Facility*	Item will allow CMS to evaluate effect of program interruptions on quality measures and will allows providers to skip next two items if response is 0.
Planned Discharge and Unplanned Discharge	Item A2510	Add item A2510: Number of Program Interruptions During This Stay in This Facility. *Code only if A2500 is equal to or greater than 1.* Enter Number ☐☐	Item will allow CMS to evaluate effect of program interruptions on quality measures.

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LTCH CARE Data Set Affected	Section or Item Number	Change	Rationale
Planned Discharge and Unplanned Discharge	Item A2520	Add item A2520: Program Interruption Dates. *Code only if Item A2510 is equal to or greater than 00)* A1. Most Recent Interruption Start Date ☐☐ - ☐☐ - ☐☐☐☐ Month Day Year A2. Most Recent Interruption End Date ☐☐ - ☐☐ - ☐☐☐☐ Month Day Year B1. Second Most Recent Interruption Start Date (code only if Item A2510 is greater than 01) ☐☐ - ☐☐ - ☐☐☐☐ Month Day Year B2. Second Most Recent Interruption End Date (code only if Item A2510 is greater than 01) ☐☐ - ☐☐ - ☐☐☐☐ Month Day Year C1. Third Most Recent Interruption Start Date (code only if item A2510 is greater than 02) ☐☐ - ☐☐ - ☐☐☐☐ Month Day Year C2. Third Most Recent Interruption End Date (code only if item A2510 is greater than 02) ☐☐ - ☐☐ - ☐☐☐☐ Month Day Year	Item will allow CMS to evaluate effect of program interruptions on quality measures.
Planned Discharge, Unplanned Discharge, and Admission	Section O	Add new Section O: Major Treatments, Procedures, and Clinical Data	Section will capture data needed for NQF# 0680 Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay)

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Admission, Planned Discharge, Unplanned Discharge	Item O0250A	Add item O0250A: Did the patient receive the influenza vaccine <u>in this facility</u> for this year's influenza vaccination season? 0. No → Skip to O0050C, If influenza vaccine not received, state reason 1. Yes → Continue to O0250B, Date influenza vaccine received	Item will capture if the patient received the influenza vaccine
Admission, Planned Discharge, Unplanned Discharge	Item O0250B	Add item O0250B: Date influenza vaccine received → Complete date and skip to Z0400, Signature of Persons Completing the Assessment ☐☐ - ☐☐ - ☐☐☐☐ Month Day Year	Item will capture when patient received the influenza vaccine for those who received one.
Admission, Planned Discharge, Unplanned Discharge	Item O0250C	Add item O0250C: If influenza vaccine not received, state reason: 1. Patient not in this facility during this year's flu 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 7. None of the above	Item will capture why vaccine was not received for those who did not receive one.
Admission, Planned Discharge, Unplanned Discharge, and Expired	Section M	Change instances of non-removable to nonremovable	Changed to reflect correct grammar
Admission, Planned Discharge, Unplanned Discharge, and Admission	Item A0055	Remove item A0055: Type of Record ☐☐ Enter the number of correction requests to modify/inactivate the existing record, including the present one. Enter 00 for a new record.	Item will be captured using the LTCH Assessment Submission Evaluation Record (LASER)
Admission	Item A1050	Remove item A1050: What is the highest degree or level of school this patient has completed?	To reduce provider burden
Admission	Item A1300D	Remove item A1300D: Lifetime Occupation(s)	To reduce provider burden

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LTCH CARE Data Set Affected	Section or Item Number	Change	Rationale
Admission	Item A1810	Remove item A1810: In the last 2 months, what other medical services besides those identified in A1800 has the patient received	To reduce provider burden
Admission	Item A1820	Remove item A1820: What was the primary diagnosis being treated in the previous setting?	To reduce provider burden
Planned Discharge	Item A1955	Remove Item A1955: Discharge Delay	To reduce provider burden
Planned Discharge	Item A1960	Remove Item A1960: Reason for Discharge Delay	To reduce provider burden
Planned Discharge, Unplanned Discharge	Item A1970	Remove Item A1970: Discharge return status	To reduce provider burden
Admission, Planned Discharge, Unplanned Discharge	Item M0210	Option 0. No Skip Pattern revised to Skip to O2500, Influenza Vaccine.	Revised to address change in skip patern
Admission	Item M0300G 1	Change skip pattern to: Skip to O0250, Influenza Vaccine.	Revised to address change in skip patern
Admission, Planned Discharge, Unplanned Discharge	Item M0300B3	Remove Item M0300B3: Date of Oldest Stage 2 pressure ulcer	To reduce provider burden
Admission, Planned Discharge, Unplanned Discharge	Item M0610	Remove Item M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar	To reduce provider burden
Admission, Unplanned Discharge, and Planned Discharge	Item M0700	Remove Item M0700: Most Severe Tissue Type for Any Pressure Ulcer	To reduce provider burden
Unplanned Discharge, Planned Discharge	Section B	Remove section B Hearing, Speech, Vision B0100. Comatose Persistent vegetative state/no discernible consciousness at time of assessment 0. No 1. Yes	This item is used as a covariate for the Pressure Ulcer Measure. The measure asks providers to assess persistent vegetative state at admission, but does not require a reassessment at discharge.

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Unplanned Discharge, Planned Discharge	Section GG	Remove section GG Functional Status: Usual Performance GG0160. Functional Mobility a. Roll left and right b. Sit to lying c. Lying to Sitting on Side of Bed	This item is used as a covariate for the Pressure Ulcer measure. The measure asks providers to assess function at admission, but does not require a reassessment at discharge.
Unplanned Discharge, Planned Discharge	Section H	Remove section H Bladder and Bowel H0400. Bowel Incontinence 0. Always continent 1. Occasionally incontinent 2. Frequently incontinent 3. Always Incontinent 4. Not rated	This item is used as a covariate for the Pressure Ulcer measure. The measure asks providers to assess bowel incontinence at admission, but does not require a reassessment at discharge
Unplanned Discharge, Planned Discharge	Section I	Remove section I Active Diagnoses I0900. Peripheral Vascular Disease (PVD) or Peripheral Artery Disease (PAD) I2900. Diabetes Mellitus (DM) I5600. Malnutrition	This item is used as a covariate for the Pressure Ulcer measure. The measure asks providers to list active diagnoses at admission, but does not require a reassessment at discharge
Unplanned Discharge, Planned Discharge	Section K	Remove section K Swallowing/Nutritional Status K0200. Height and Weight a. Height b. Weight	This item is used as a covariate for the Pressure Ulcer measure. The measure asks providers to measure height and weight at admission, but does not require a reassessment at discharge