Patient _____ Identifier _____ Date _____

# LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 4.00

## 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 C Cognitive Patterns

**C1310. Signs and Symptoms of Delirium (from CAM©)** (within the last 7 days)

**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

# 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 Ulcers/Injuries*
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 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 N2005, Medication Intervention*
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 ☐

**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*

Enter Number ☐

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 ☐

**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*

Enter Number ☐

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 ☐

**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*

Enter Number ☐

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 ☐

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

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

Enter Number ☐

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 ☐

**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*

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

**M0300 continued on next page**

| Section M | Skin Conditions |
|---|---|

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

| Enter Number | |
|---|---|
| ☐ | **G. Unstageable - Deep tissue injury**<br><br>1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → *Skip to N2005, Medication Intervention*<br><br>2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission** - enter how many were noted at the time of admission |
| Enter Number<br>☐ | |

## Section N Medications

### 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. **NA - 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

## O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last 14 days.

| | 4. Performed during the last 14 days<br>Check all that apply ↓ |
|---|---|
| **Respiratory Treatments** | |
| **D. Suctioning** (if checked, please specify below) | ☐ |
| D2a. Scheduled | ☐ |
| D3a. As needed | ☐ |
| **E. Tracheostomy Care** | ☐ |
| **None of the Above** | |
| **Z. None of the above** | ☐ |

## O0200. Ventilator Liberation Rate

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. NA** (code only if the patient was non-weaning or not ventilated on admission [O0150A=2 or 0 on Admission Assessment])

## 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 | | | |

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