

Proposed LTCH QRP New and Modified Items
Effective Date: October 1, 2020

ADMISSION

Section A	Administrative Information
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A1005. Ethnicity
 Are you Hispanic, Latino/a, or Spanish origin?

↓ **Check all that apply**

<input type="checkbox"/>	A. No, not of Hispanic, Latino/a, or Spanish origin
<input type="checkbox"/>	B. Yes, Mexican, Mexican American, Chicano/a
<input type="checkbox"/>	C. Yes, Puerto Rican
<input type="checkbox"/>	D. Yes, Cuban
<input type="checkbox"/>	E. Yes, Another Hispanic, Latino, or Spanish origin
<input type="checkbox"/>	X. Patient unable to respond

A1010. Race
 What is your race?

↓ **Check all that apply**

<input type="checkbox"/>	A. White
<input type="checkbox"/>	B. Black or African American
<input type="checkbox"/>	C. American Indian or Alaska Native
<input type="checkbox"/>	D. Asian Indian
<input type="checkbox"/>	E. Chinese
<input type="checkbox"/>	F. Filipino
<input type="checkbox"/>	G. Japanese
<input type="checkbox"/>	H. Korean
<input type="checkbox"/>	I. Vietnamese
<input type="checkbox"/>	J. Other Asian
<input type="checkbox"/>	K. Native Hawaiian
<input type="checkbox"/>	L. Guamanian or Chamorro
<input type="checkbox"/>	M. Samoan
<input type="checkbox"/>	N. Other Pacific Islander
<input type="checkbox"/>	X. Patient unable to respond

A1110. Language

Enter Code <input type="checkbox"/>	A. What is your preferred language? <input type="text"/>
	B. Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes 9. Unable to determine

A1250. Transportation	
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	
↓ Check all that apply	
<input type="checkbox"/>	A. Yes , it has kept me from medical appointments or from getting my medications
<input type="checkbox"/>	B. Yes , it has kept me from non-medical meetings, appointments, work, or from getting things that I need
<input type="checkbox"/>	C. No
<input type="checkbox"/>	D. Patient unable to respond

A1805. Admitted From	
Enter Code <input type="text"/>	<ul style="list-style-type: none"> 01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 02. Nursing home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) 08. Intermediate Care Facility (ID/DD facility) 09. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service organization 99. Not Listed

Section B	Hearing, Speech, and Vision
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B0200. Hearing	
Enter Code <input type="text"/>	<p>Ability to hear (with hearing aid or hearing appliances if normally used)</p> <ul style="list-style-type: none"> 0. Adequate – no difficulty in normal conversation, social interaction, listening to TV 1. Minimal difficulty – difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. Moderate difficulty – speaker has to increase volume and speak distinctly 3. Highly impaired – absence of useful hearing

B1000. Vision	
Enter Code <input type="checkbox"/>	<p>Ability to see in adequate light (with glasses or other visual appliances)</p> <p>0. Adequate – sees fine detail, such as regular print in newspapers/books</p> <p>1. Impaired – sees large print, but not regular print in newspapers/books</p> <p>2. Moderately impaired – limited vision; not able to see newspaper headlines but can identify objects</p> <p>3. Highly impaired – object identification in question, but eyes appear to follow objects</p> <p>4. Severely impaired – no vision or sees only light, colors or shapes; eyes do not appear to follow objects</p>

B1300. Health Literacy	
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
Enter Code <input type="checkbox"/>	<p>0. Never</p> <p>1. Rarely</p> <p>2. Sometimes</p> <p>3. Often</p> <p>4. Always</p> <p>9. Patient unable to respond</p>

Section C	Cognitive Patterns
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C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?	
Attempt to conduct interview with all patients.	
Enter Code <input type="checkbox"/>	<p>0. No (patient is rarely/never understood) → <i>Skip to XXXX</i></p> <p>1. Yes → <i>Continue to C0200, Repetition of Three Words</i></p>

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words	
Enter Code <input type="checkbox"/>	<p>Ask patient: <i>"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."</i></p> <p>Number of words repeated after first attempt</p> <p>0. None</p> <p>1. One</p> <p>2. Two</p> <p>3. Three</p> <p>After the patient's first attempt, repeat the words using cues (<i>"sock, something to wear; blue, a color; bed, a piece of furniture"</i>). You may repeat the words up to two more times.</p>

C0300. Temporal Orientation (orientation to year, month, and day)	
Enter Code <input type="checkbox"/>	<p>Ask patient: <i>"Please tell me what year it is right now."</i></p> <p>A. Able to report correct year</p> <p>0. Missed by > 5 years or no answer</p> <p>1. Missed by 2-5 years</p> <p>2. Missed by 1 year</p> <p>3. Correct</p>

Enter Code <input type="checkbox"/>	Ask patient: <i>"What month are we in right now?"</i> B. Able to report correct month 0. Missed by > 1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
Enter Code <input type="checkbox"/>	Ask patient: <i>"What day of the week is today?"</i> C. Able to report correct day of the week 0. Incorrect or no answer 1. Correct
C0400. Recall	
Enter Code <input type="checkbox"/>	Ask patient: <i>"Let's go back to an earlier question. What were those three words that I asked you to repeat?"</i> If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. Able to recall "sock" 0. No- could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required
Enter Code <input type="checkbox"/>	B. Able to recall "blue" 0. No- could not recall 1. Yes, after cueing ("a color") 2. Yes, no cue required
Enter Code <input type="checkbox"/>	C. Able to recall "bed" 0. No- could not recall 1. Yes, after cueing ("a piece of furniture") 2. Yes, no cue required
C0500. BIMS Summary Score	
Enter Score <input type="text"/>	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview

C1310. Signs and Symptoms of Delirium (from CAM©)	
Code after completing Brief Interview for Mental Status and reviewing medical record.	
A. Acute Onset Mental Status Change	
Enter Code <input type="checkbox"/>	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	↓ Enter Code in Boxes
	<input type="checkbox"/> B. Inattention - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/> 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)?

<p>not fluctuate</p> <p>2. Behavior present, fluctuates (comes and goes, changes in severity)</p>	<input data-bbox="443 174 495 226" type="checkbox"/>	<p>D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria?</p> <ul style="list-style-type: none"> ▪ 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
<p><i>Confusion Assessment Method. © 1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.</i></p>		

Section D	Mood
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D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"
 If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
 If yes in column 1, then ask the patient: "About **how often** have you been bothered by this?"
 Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence	2. Symptom Frequency	1.	2.
0. No (enter 0 in column 2)	0. Never or 1 day	Symptom Presence	Symptom Frequency
1. Yes (enter 0-3 in column 2)	1. 2-6 days (several days)	↓Enter Scores in Boxes↓	
9. No response (leave column 2 blank)	2. 7-11 days (half or more of the days)		
	3. 12-14 days (nearly every day)		

A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>
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B. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>
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If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview and SKIP to next section.

C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>
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D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>
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E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>
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F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>
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G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>
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H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>
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I. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>
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D0160. Total Severity Score

Enter Score <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)
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D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code

- 0. **Never**
- 1. **Rarely**
- 2. **Sometimes**
- 3. **Often**
- 4. **Always**
- 9. **Patient unable to respond**

Section GG**Functional Abilities and Goals****GG0170. Mobility** (3-day assessment period)

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	F. Toilet transfer: The ability to get on and off a toilet or commode. <i>If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170I, Walk 10 feet</i>

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. <i>If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)</i>

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. <i>If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object</i>

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail. <i>If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object</i>

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

Section J	Health Conditions
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J0510. Pain Effect on Sleep

Enter Code <input type="checkbox"/>	<p><i>Ask patient: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"</i></p> <p>0. Does not apply – I have not had any pain or hurting in the past 5 days → Skip to XXXX</p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost Constantly</p> <p>9. Unable to answer</p>
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J0520. Pain Interference with Therapy Activities

Enter Code <input type="checkbox"/>	<p><i>Ask patient: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"</i></p> <p>0. Does not apply – I have not received rehabilitation therapy in the past 5 days</p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost Constantly</p> <p>9. Unable to answer</p>
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J0530. Pain Interference with Day-to-Day Activities
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Enter Code <input type="checkbox"/>	<p><i>Ask patient: "Over the past 5 days, how often have you limited your day-to-day activities (<u>excluding</u> rehabilitation therapy sessions) because of pain?"</i></p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost Constantly</p> <p>9. Unable to answer</p>
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Section K	Swallowing/Nutritional Status
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K0520. Nutritional Approaches	
Check all of the following nutritional approaches that apply on admission.	
↓ Check all that apply	
<input type="checkbox"/>	A. Parenteral/IV feeding
<input type="checkbox"/>	B. Feeding tube (e.g., nasogastric or abdominal (PEG))
<input type="checkbox"/>	C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
<input type="checkbox"/>	D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
<input type="checkbox"/>	Z. None of the above

Section N	Medications
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N0415. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the patient is taking any medications in the following drug classes 2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is taking	2. Indication noted
	Check all that apply ↓	Check all that apply ↓
A. Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>

Section O	Special Treatments, Procedures, and Programs
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00110. Special Treatments, Procedures, and Programs
 Check all of the following treatments, procedures, and programs that apply on admission.

↓ Check all that apply

Cancer Treatments

<input type="checkbox"/>	A1. Chemotherapy
	<input type="checkbox"/> A2. IV <input type="checkbox"/> A3. Oral <input type="checkbox"/> A10. Other
<input type="checkbox"/>	B1. Radiation

Respiratory Therapies

<input type="checkbox"/>	C1. Oxygen Therapy
	<input type="checkbox"/> C2. Continuous <input type="checkbox"/> C3. Intermittent <input type="checkbox"/> C4. High-concentration
<input type="checkbox"/>	D1. Suctioning
	<input type="checkbox"/> D2. Scheduled <input type="checkbox"/> D3. As Needed
<input type="checkbox"/>	E1. Tracheostomy Care
<input type="checkbox"/>	G1. Non-invasive Mechanical Ventilator
	<input type="checkbox"/> G2. BiPAP <input type="checkbox"/> G3. CPAP

Other

<input type="checkbox"/>	H1. IV Medications
	<input type="checkbox"/> H2. Vasoactive medications <input type="checkbox"/> H3. Antibiotics <input type="checkbox"/> H4. Anticoagulation <input type="checkbox"/> H10. Other
<input type="checkbox"/>	I1. Transfusions
<input type="checkbox"/>	J1. Dialysis
	<input type="checkbox"/> J2. Hemodialysis <input type="checkbox"/> J3. Peritoneal dialysis

<input type="checkbox"/>	O1. IV Access
	<input type="checkbox"/> O2. Peripheral <input type="checkbox"/> O3. Midline <input type="checkbox"/> O4. Central (e.g., PICC, tunneled, port)
None of the Above	
<input type="checkbox"/>	Z1. None of the above

00150. Spontaneous Breathing Trial (SBT) (including Tracheostomy Collar Trial (TCT) or Continuous Positive Airway Pressure (CPAP) Breathing Trial) by Day 2 of the LTCH Stay (Note: Day 2 = Date of Admission to the LTCH (Day 1) + 1 calendar day)	
Enter Code <input type="checkbox"/>	A. Invasive Mechanical Ventilation Support upon Admission to the LTCH 0. No, not on invasive mechanical ventilation support upon admission → <i>Skip to Z0400, Signature of Persons Completing the Assessment</i> 1. Yes, on invasive mechanical ventilation support upon admission → <i>Continue to O0150A2, Ventilator Weaning Status</i>
Enter Code <input type="checkbox"/>	A2. Ventilator Weaning Status 0. No, determined to be non-weaning upon admission → <i>Skip to Z0400, Signature of Persons Completing the Assessment</i> 1. Yes, determined to be weaning upon admission → <i>Continue to O0150B, Assessed for readiness for SBT by day 2 of LTCH stay</i>
Enter Code <input type="checkbox"/>	B. Assessed for readiness for SBT by day 2 of the LTCH stay 0. No → <i>Skip to Z0400, Signature of Persons Completing the Assessment</i> 1. Yes → <i>Continue to O0150C, Deemed medically ready for SBT by day 2 of the LTCH stay</i>
Enter Code <input type="checkbox"/>	C. Deemed medically ready for SBT by day 2 of the LTCH stay 0. No → <i>Continue to O0150D, Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?</i> 1. Yes → <i>Continue to O0150E, If the patient was deemed medically ready for SBT, was SBT performed by day 2 of the LTCH stay?</i>
Enter Code <input type="checkbox"/>	D. Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay? 0. No → <i>Skip to Z0400, Signature of Persons Completing the Assessment</i> 1. Yes → <i>Skip to Z0400, Signature of Persons Completing the Assessment</i>
Enter Code <input type="checkbox"/>	E. If the patient was deemed medically ready for SBT, was SBT performed by day 2 of the LTCH stay? 0. No 1. Yes

PLANNED DISCHARGE

Section A

Administrative Information

A1110. Language

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>A. What is your preferred language?</p> <div style="border: 1px solid black; width: 100%; height: 15px; margin-bottom: 10px;"></div> <p>B. Do you need or want an interpreter to communicate with a doctor or health care staff?</p> <p>0. No</p> <p>1. Yes</p> <p>9. Unable to determine</p>
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A1250. Transportation

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

↓ Check all that apply

<input type="checkbox"/>	A. Yes , it has kept me from medical appointments or from getting my medications
<input type="checkbox"/>	B. Yes , it has kept me from non-medical meetings, appointments, work, or from getting things that I need
<input type="checkbox"/>	C. No
<input type="checkbox"/>	D. Patient unable respond

A2105. Discharge Location

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)</p> <p>02. Nursing home (long-term care facility)</p> <p>03. Skilled Nursing Facility (SNF, swing beds)</p> <p>04. Short-term General Hospital (acute hospital, IPPS)</p> <p>05. Long-Term Care Hospital (LTCH)</p> <p>06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit)</p> <p>07. Inpatient Psychiatric Facility (psychiatric hospital or unit)</p> <p>08. Intermediate Care Facility (ID/DD facility)</p> <p>09. Hospice (home/non-institutional)</p> <p>10. Hospice (institutional facility)</p> <p>11. Critical Access Hospital (CAH)</p> <p>12. Home under care of organized home health service organization</p> <p>99. Not Listed</p>
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A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

At the time of discharge to another provider, did your facility provide the patient's current reconciled medication list to the subsequent provider?

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>0. No – Current reconciled medication list not provided to the subsequent provider</p> <p>1. Yes – Current reconciled medication list provided to the subsequent provider</p>
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A2122. Provision of Current Reconciled Medication List to Patient at Discharge	
At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?	
Enter Code <input type="checkbox"/>	<p>0. No – Current reconciled medication list not provided to the patient, family and/or caregiver</p> <p>1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver</p>

A2123. Route of Current Reconciled Medication List Transmission		
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver.		
Route of Transmission	1. To subsequent provider	2. To patient/family/caregiver
	↓ Check all that apply ↓	
A. Electronic Health Record	<input type="checkbox"/>	<input type="checkbox"/>
B. Health Information Exchange Organization	<input type="checkbox"/>	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>	<input type="checkbox"/>

Section B	Hearing, Speech, and Vision
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B1300. Health Literacy	
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
Enter Code <input type="checkbox"/>	<p>0. Never</p> <p>1. Rarely</p> <p>2. Sometimes</p> <p>3. Often</p> <p>4. Always</p> <p>9. Patient unable to respond</p>

Section C	Cognitive Patterns
------------------	---------------------------

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? Attempt to conduct interview with all patients.

Enter Code <input type="checkbox"/>	<p>0. No (patient is rarely/never understood) → <i>Skip to XXXX</i></p> <p>1. Yes → <i>Continue to C0200, Repetition of Three Words</i></p>
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Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code <input type="checkbox"/>	<p>Ask patient: <i>"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue and bed. Now tell me the three words."</i></p> <p>Number of words repeated after first attempt</p> <p>0. None</p> <p>1. One</p> <p>2. Two</p> <p>3. Three</p> <p>After the patient's first attempt, repeat the words using cues (<i>"sock, something to wear; blue, a color; bed, a piece of furniture"</i>). You may repeat the words up to two more times.</p>
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C0300. Temporal Orientation (orientation to year, month, and day)
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Enter Code <input type="checkbox"/>	<p>Ask patient: <i>"Please tell me what year it is right now."</i></p> <p>A. Able to report correct year</p> <p>0. Missed by > 5 years or no answer</p> <p>1. Missed by 2-5 years</p> <p>2. Missed by 1 year</p> <p>3. Correct</p>
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Enter Code <input type="checkbox"/>	<p>Ask patient: <i>"What month are we in right now?"</i></p> <p>B. Able to report correct month</p> <p>0. Missed by > 1 month or no answer</p> <p>1. Missed by 6 days to 1 month</p> <p>2. Accurate within 5 days</p>
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Enter Code <input type="checkbox"/>	<p>Ask patient: <i>"What day of the week is today?"</i></p> <p>C. Able to report correct day of the week</p> <p>0. Incorrect or no answer</p> <p>1. Correct</p>
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C0400. Recall

Enter Code <input type="checkbox"/>	<p>Ask patient: <i>"Let's go back to an earlier question. What were those three words that I asked you to repeat?"</i> If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.</p> <p>A. Able to recall "sock"</p> <p>0. No- could not recall</p> <p>1. Yes, after cueing ("something to wear")</p> <p>2. Yes, no cue required</p>
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Enter Code <input type="checkbox"/>	<p>B. Able to recall "blue"</p> <p>0. No- could not recall</p> <p>1. Yes, after cueing ("a color")</p> <p>2. Yes, no cue required</p>
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Enter Code <input type="checkbox"/>	C. Able to recall "bed" 0. No - could not recall 1. Yes, after cueing ("a piece of furniture") 2. Yes, no cue required
C0500. BIMS Summary Score	
Enter Score <input type="text"/>	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview

C1310. Signs and Symptoms of Delirium (from CAM©)	
Code after completing Brief Interview for Mental Status and reviewing medical record.	
A. Acute Onset Mental Status Change	
Enter Code <input type="checkbox"/>	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
	<input type="checkbox"/> B. Inattention - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/> 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)?
<input type="checkbox"/> D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria? <ul style="list-style-type: none"> ▪ 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 	
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Section D	Mood
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D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "Over the last 2 weeks, have you been bothered by any of the following problems?"
 If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
 If yes in column 1, then ask the patient: "About **how often** have you been bothered by this?"
 Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence	2. Symptom Frequency	1.	2.
0. No (enter 0 in column 2)	0. Never or 1 day	Symptom Presence	Symptom Frequency
1. Yes (enter 0-3 in column 2)	1. 2-6 days (several days)	↓ Enter Scores in Boxes ↓	
9. No response (leave column 2 blank)	2. 7-11 days (half or more of the days)		
	3. 12-14 days (nearly every day)		

A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>
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B. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>
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If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview and SKIP to next section.

C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>
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D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------

E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>
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F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>
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G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------

H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>
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I. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>
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D0160. Total Severity Score

Enter Score <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<p>Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.</p> <p>Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)</p>
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D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code

- 0. **Never**
- 1. **Rarely**
- 2. **Sometimes**
- 3. **Often**
- 4. **Always**
- 9. **Patient unable to respond**

Section GG**Functional Abilities and Goals****GG0170. Mobility** (3-day assessment period)

3.
Discharge
Performance

↓ Enter Codes in Boxes

F. Toilet transfer: The ability to get on and off a toilet or commode. *If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170I, Walk 10 feet*

3.
Discharge
Performance

↓ Enter Codes in Boxes

I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)*

3.
Discharge
Performance

↓ Enter Codes in Boxes

G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.

3.
Discharge
Performance

↓ Enter Codes in Boxes

L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

3. Discharge Performance	
↓ Enter Codes in Boxes	
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. <i>If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object</i>

3. Discharge Performance	
↓ Enter Codes in Boxes	
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail. <i>If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object</i>

3. Discharge Performance	
↓ Enter Codes in Boxes	
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.

3. Discharge Performance	
↓ Enter Codes in Boxes	
<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

Section J	Health Conditions
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J0510. Pain Effect on Sleep	
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Enter Code <input type="checkbox"/>	<p><i>Ask patient: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"</i></p> <p>0. Does not apply – I have not had any pain or hurting in the past 5 days → <i>Skip to XXXX</i></p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost Constantly</p> <p>9. Unable to answer</p>
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J0520. Pain Interference with Therapy Activities	
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Enter Code <input type="checkbox"/>	<p><i>Ask patient: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"</i></p> <p>0. Does not apply – I have not received rehabilitation therapy in the past 5 days</p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost Constantly</p> <p>9. Unable to answer</p>
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J0530. Pain Interference with Day-to-Day Activities	
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Enter Code <input type="checkbox"/>	<p><i>Ask patient: "Over the past 5 days, how often have you limited your day-to-day activities (<u>excluding</u> rehabilitation therapy sessions) because of pain?"</i></p> <p>1. Rarely or not at all</p> <p>2. Occasionally</p> <p>3. Frequently</p> <p>4. Almost Constantly</p> <p>9. Unable to answer</p>
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Section K	Swallowing/Nutritional Status
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K0520. Nutritional Approaches		
1. Last 7 days Check all of the nutritional approaches that were received in the last 7 days 2. At discharge Check all of the nutritional approaches that were being received at discharge	1. Last 7 days	2. At discharge
	Check all that apply ↓	Check all that apply ↓
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Section N	Medications
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N0420. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the patient is taking any medications in the following drug classes 2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is taking	2. Indication noted
	Check all that apply ↓	Check all that apply ↓
A. Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>

Section O	Special Treatments, Procedures, and Programs
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00110. Special Treatments, Procedures, and Programs
 Check all of the following treatments, procedures, and programs that apply at discharge.

↓ Check all that apply

Cancer Treatments

<input type="checkbox"/>	A1. Chemotherapy
	<input type="checkbox"/> A2. IV <input type="checkbox"/> A3. Oral <input type="checkbox"/> A10. Other
<input type="checkbox"/>	B1. Radiation

Respiratory Therapies

<input type="checkbox"/>	C1. Oxygen Therapy
	<input type="checkbox"/> C2. Continuous <input type="checkbox"/> C3. Intermittent <input type="checkbox"/> C4. High-concentration
<input type="checkbox"/>	D1. Suctioning
	<input type="checkbox"/> D2. Scheduled <input type="checkbox"/> D3. As Needed
<input type="checkbox"/>	E1. Tracheostomy Care
<input type="checkbox"/>	F1. Invasive Mechanical Ventilator (ventilator or respirator)
<input type="checkbox"/>	G1. Non-invasive Mechanical Ventilator
	<input type="checkbox"/> G2. BiPAP <input type="checkbox"/> G3. CPAP

Other

<input type="checkbox"/>	H1. IV Medications
	<input type="checkbox"/> H2. Vasoactive medications <input type="checkbox"/> H3. Antibiotics <input type="checkbox"/> H4. Anticoagulation <input type="checkbox"/> H10. Other
<input type="checkbox"/>	I1. Transfusions
<input type="checkbox"/>	J1. Dialysis
	<input type="checkbox"/> J2. Hemodialysis <input type="checkbox"/> J3. Peritoneal dialysis

<input type="checkbox"/>	O1. IV Access
	<input type="checkbox"/> O2. Peripheral <input type="checkbox"/> O3. Midline <input type="checkbox"/> O4. Central (e.g., PICC, tunneled, port)
None of the Above	
<input type="checkbox"/>	Z1. None of the above

O0200. Ventilator Liberation Rate (Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge)	
Enter Code <input type="checkbox"/>	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. Not applicable (code only if the patient was not on invasive mechanical ventilator support upon <u>admission</u> [O0150A = 0] or the patient was determined to be non-weaning upon <u>admission</u> [O0150A2 = 0])

UNPLANNED DISCHARGE

Section A

Administrative Information

A1990. Patient Discharged Against Medical Advice?

Enter Code

- 0. No
- 1. Yes

A2105. Discharge Location

Enter Code

- 01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
- 02. **Nursing home** (long-term care facility)
- 03. **Skilled Nursing Facility** (SNF, swing beds)
- 04. **Short-term General Hospital** (acute hospital, IPPS)
- 05. **Long-Term Care Hospital** (LTCH)
- 06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
- 07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
- 08. **Intermediate Care Facility** (ID/DD facility)
- 09. **Hospice** (home/non-institutional)
- 10. **Hospice** (institutional facility)
- 11. **Critical Access Hospital** (CAH)
- 12. **Home under care of organized home health service organization**
- 99. **Not Listed**

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

At the time of discharge to another provider, did your facility provide the patient's current reconciled medication list to the subsequent provider?

Enter Code

- 0. **No** – Current reconciled medication list not provided to the subsequent provider
- 1. **Yes** – Current reconciled medication list provided to the subsequent provider

A2122. Provision of Current Reconciled Medication List to Patient at Discharge

At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver?

Enter Code

- 0. **No** – Current reconciled medication list not provided to the patient, family and/or caregiver
- 1. **Yes** – Current reconciled medication list provided to the patient, family and/or caregiver

A2123. Route of Current Reconciled Medication List Transmission

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider and/or patient/family/caregiver.

Route of Transmission	1. To subsequent provider	2. To patient/family/caregiver
	↓ Check all that apply ↓	
A. Electronic Health Record	<input type="checkbox"/>	<input type="checkbox"/>
B. Health Information Exchange Organization	<input type="checkbox"/>	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<input type="checkbox"/>	<input type="checkbox"/>

Section C Cognitive Patterns

C1310. Signs and Symptoms of Delirium (from CAM©)

Code after reviewing medical record.

A. Acute Onset Mental Status Change

Enter Code	<input type="checkbox"/> 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	
	<input type="checkbox"/>	B. Inattention - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/>	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)?
	<input type="checkbox"/>	D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria? <ul style="list-style-type: none"> ▪ 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

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Section K	Swallowing/Nutritional Status
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K0520. Nutritional Approaches		
1. Last 7 days Check all of the nutritional approaches that were received in the last 7 days 2. At discharge Check all of the nutritional approaches that were being received at discharge	1. Last 7 days	2. At discharge
	Check all that apply ↓	Check all that apply ↓
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Section N	Medications
------------------	--------------------

N0420. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the patient is taking any medications in the following drug classes 2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class	1. Is taking	2. Indication noted
	Check all that apply ↓	Check all that apply ↓
A. Antipsychotic	<input type="checkbox"/>	<input type="checkbox"/>
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>

Section O	Special Treatments, Procedures, and Programs
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00110. Special Treatments, Procedures, and Programs
 Check all of the following treatments, procedures, and programs that apply at discharge.

↓ Check all that apply

Cancer Treatments

<input type="checkbox"/>	A1. Chemotherapy
	<input type="checkbox"/> A2. IV <input type="checkbox"/> A3. Oral <input type="checkbox"/> A10. Other
<input type="checkbox"/>	B1. Radiation

Respiratory Therapies

<input type="checkbox"/>	C1. Oxygen Therapy
	<input type="checkbox"/> C2. Continuous <input type="checkbox"/> C3. Intermittent <input type="checkbox"/> C4. High-concentration
<input type="checkbox"/>	D1. Suctioning
	<input type="checkbox"/> D2. Scheduled <input type="checkbox"/> D3. As Needed
<input type="checkbox"/>	E1. Tracheostomy Care
<input type="checkbox"/>	F1. Invasive Mechanical Ventilator (ventilator or respirator)
<input type="checkbox"/>	G1. Non-invasive Mechanical Ventilator
	<input type="checkbox"/> G2. BiPAP <input type="checkbox"/> G3. CPAP

Other

<input type="checkbox"/>	H1. IV Medications
	<input type="checkbox"/> H2. Vasoactive medications <input type="checkbox"/> H3. Antibiotics <input type="checkbox"/> H4. Anticoagulation <input type="checkbox"/> H10. Other
<input type="checkbox"/>	I1. Transfusions
<input type="checkbox"/>	J1. Dialysis
	<input type="checkbox"/> J2. Hemodialysis <input type="checkbox"/> J3. Peritoneal dialysis

<input type="checkbox"/>	O1. IV Access
	<input type="checkbox"/> O2. Peripheral <input type="checkbox"/> O3. Midline <input type="checkbox"/> O4. Central (e.g., PICC, tunneled, port)
None of the Above	
<input type="checkbox"/>	Z1. None of the above

O0200. Ventilator Liberation Rate (Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge)	
Enter Code <input type="checkbox"/>	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. Not applicable (code only if the patient was not on invasive mechanical ventilator support upon <u>admission</u> [O0150A = 0] or the patient was determined to be non-weaning upon <u>admission</u> [O0150A2 = 0])