

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 (Expiration Date: XX/XX/XXXX)**. The time required to complete this information collection is estimated to average **24 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. *******CMS Disclaimer*****Please do not send applications, claims, payments, medical records, or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Christy Hughes at Christy.Hughes@cms.hhs.gov.**

LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD & EVALUATION (CARE) DATA SET - Version 5.00 PATIENT ASSESSMENT FORM - UNPLANNED DISCHARGE

Section A	Administrative Information
------------------	-----------------------------------

A0050. Type of Record

Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 1. Add new assessment/record 2. Modify existing record 3. Inactivate existing record
---	---

A0100. Facility Provider Numbers. Enter Code in boxes provided.

	<p>A. National Provider Identifier (NPI):</p> <p>B. CMS Certification Number (CCN):</p> <p>C. State Medicaid Provider Number:</p>
--	--

A0200. Type of Provider

Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 3. Long-Term Care Hospital
---	---

A0210. Assessment Reference Date

	<p>Observation end date:</p> <p style="text-align: center;"> -- -- Month Day Year </p>
--	--

A0220. Admission Date

	<p style="text-align: center;"> -- -- Month Day Year </p>
--	---

A0250. Reason for Assessment

Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<ol style="list-style-type: none"> 01. Admission 10. Planned discharge 11. Unplanned discharge 12. Expired
---	--

A0270. Discharge Date

	<p style="text-align: center;"> -- -- Month Day Year </p>
--	---

Section A	Administrative Information
------------------	-----------------------------------

Patient Demographic Information
--

A0500. Legal Name of Patient

	<p>A. First name:</p> <p>B. Middle initial:</p> <p>C. Last name:</p> <p>D. Suffix:</p>
--	---

A0600. Social Security and Medicare Numbers
--

	<p>A. Social Security Number:</p> <p style="text-align: center;">- -</p> <p>B. Medicare number (or comparable railroad insurance number):</p>
--	---

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

--	--

A0800. Gender

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>1. Male</p> <p>2. Female</p>
---	---

A0900. Birth Date

	<p>- -</p> <p>Month Day Year</p>
--	--

Section A	Administrative Information
------------------	-----------------------------------

A1400. Payer Information

↓ Check all that apply	
<input type="checkbox"/>	A. Medicare (traditional fee-for-service)
<input type="checkbox"/>	B. Medicare (managed care/Part C/Medicare Advantage)
<input type="checkbox"/>	C. Medicaid (traditional fee-for-service)
<input type="checkbox"/>	D. Medicaid (managed care)
<input type="checkbox"/>	E. Workers' compensation
<input type="checkbox"/>	F. Title programs (e.g., Title III, V, or XX)
<input type="checkbox"/>	G. Other government (e.g., TRICARE, VA, etc.)
<input type="checkbox"/>	H. Private insurance/Medigap
<input type="checkbox"/>	I. Private managed care
<input type="checkbox"/>	J. Self-pay
<input type="checkbox"/>	K. No payer source
<input type="checkbox"/>	X. Unknown
<input type="checkbox"/>	Y. Other

A1990. Patient Discharged Against Medical Advice?
--

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	0. No 1. Yes
---	-------------------------------

A2105. Discharge Location

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	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 bed) 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 A	Administrative Information
------------------	-----------------------------------

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:30px; height:20px;" type="text"/>	0. No – Current reconciled medication list not provided to the subsequent provider → <i>Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge</i> 1. Yes – Current reconciled medication list provided to the subsequent provider
---	---

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
 Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

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

A2123. 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 style="width:30px; height:20px;" type="text"/>	0. No – Current reconciled medication list not provided to the patient, family and/or caregiver → <i>Skip to C1310, Signs and Symptoms of Delirium (from CAM©)</i> 1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver
---	--

A2124. Route of Current Reconciled Medication List Transmission to Patient
 Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver.

Route of Transmission	Check all that apply ↓
A. Electronic Health Record (e.g., electronic access to patient portal)	<input type="checkbox"/>
B. Health Information Exchange	<input type="checkbox"/>
C. Verbal (e.g., in-person, telephone, video conferencing)	<input type="checkbox"/>
D. Paper-based (e.g., fax, copies, printouts)	<input type="checkbox"/>
E. Other Methods (e.g., texting, email, CDs)	<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 style="width: 20px; height: 20px;" type="text"/>	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 style="width: 20px; height: 20px;" type="text"/>	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 style="width: 20px; height: 20px;" type="text"/>	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 style="width: 20px; height: 20px;" type="text"/>	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 	

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

Section J	Health Conditions
------------------	--------------------------

J1800. Any Falls Since Admission

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>Has the patient had any falls since admission?</p> <p>0. No → <i>Skip to K0520, Nutritional Approaches</i></p> <p>1. Yes → <i>Continue to J1900, Number of Falls Since Admission</i></p>
---	--

J1900. Number of Falls Since Admission

<p>Coding:</p> <p>0. None</p> <p>1. One</p> <p>2. Two or more</p>	↓	Enter Codes in Boxes	
	<input style="width: 20px; height: 20px;" type="text"/>	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.	
	<input style="width: 20px; height: 20px;" type="text"/>	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.	
	<input style="width: 20px; height: 20px;" type="text"/>	C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.	

Section K	Swallowing/Nutritional Status
------------------	--------------------------------------

K0520. Nutritional Approaches		
4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days	4. Last 7 Days	5. At Discharge
5. At Discharge Check all of the nutritional approaches that were being received 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 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 <input style="width: 100%;" type="text"/>	<p>Does this patient have one or more unhealed pressure ulcers/injuries?</p> <p>0. No → <i>Skip to N0415, High-Risk Drug Classes: Use and Indication</i></p> <p>1. Yes → <i>Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</i></p>
---	---

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

Enter Number <input style="width: 100%;" type="text"/>	<p>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.</p> <p>1. Number of Stage 1 pressure injuries</p>
---	---

Enter Number <input style="width: 100%;" type="text"/>	<p>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.</p> <p>1. Number of Stage 2 pressure ulcers - If 0 → <i>Skip to M0300C, Stage 3</i></p>
Enter Number <input style="width: 100%;" type="text"/>	<p>2. Number of these Stage 2 pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>

Enter Number <input style="width: 100%;" type="text"/>	<p>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.</p> <p>1. Number of Stage 3 pressure ulcers - If 0 → <i>Skip to M0300D, Stage 4</i></p>
Enter Number <input style="width: 100%;" type="text"/>	<p>2. Number of these Stage 3 pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>

Enter Number <input style="width: 100%;" type="text"/>	<p>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.</p> <p>1. Number of Stage 4 pressure ulcers - If 0 → <i>Skip to M0300E, Unstageable - Non-removable dressing/device</i></p>
Enter Number <input style="width: 100%;" type="text"/>	<p>2. Number of these Stage 4 pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>

Enter Number <input style="width: 100%;" type="text"/>	<p>E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 → <i>Skip to M0300F, Unstageable - Slough and/or eschar</i></p>
Enter Number <input style="width: 100%;" type="text"/>	<p>2. Number of these unstageable pressure ulcers/injuries that were present upon admission - enter how many were noted at the time of admission</p>

Enter Number <input style="width: 100%;" type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → <i>Skip to M0300G, Unstageable - Deep tissue injury</i></p>
Enter Number <input style="width: 100%;" type="text"/>	<p>2. Number of these unstageable pressure ulcers that were present upon admission - enter how many were noted at the time of admission</p>

Enter Number <input style="width: 100%;" type="text"/>	<p>G. Unstageable - Deep tissue injury</p> <p>1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → <i>Skip to N0415, High-Risk Drug Classes: Use and Indication</i></p>
Enter Number <input style="width: 100%;" type="text"/>	<p>2. Number of these unstageable pressure injuries that were present upon admission - enter how many were noted at the time of admission</p>

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

N0415. High-Risk Drug Classes: Use and Indication

1. Is taking Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following 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"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

N2005. Medication Intervention

Enter Code <input style="width:30px; height:20px;" type="text"/>	<p>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?</p> <p>0. No 1. Yes 9. Not applicable - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications</p>
---	---

Section O**Special Treatments, Procedures, and Programs****O0110. Special Treatments, Procedures, and Programs**

Check all of the following treatments, procedures, and programs that apply at discharge.

	c. At Discharge
	Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>
A10. Other	<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>
Respiratory Therapies	
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	<input type="checkbox"/>
Other	
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)	<input type="checkbox"/>
None of the Above	
Z1. None of the above	<input type="checkbox"/>

Section O**Special Treatments, Procedures, and Programs****O0200. Ventilator Liberation Rate** (Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge)

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. Not applicable** (code only if the patient was not on invasive mechanical ventilator support upon admission [O0150A = 0] or the patient was determined to be non-weaning upon admission [O0150A2 = 0])

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