CARE Tool

Interim

This instrument uses the phrase “2-day assessment period” referring to either:

1) **Select ANY two consecutive calendar days during the Cost-Resource Utilization (CRU) two-week data collection period;**

or

2) **If the patient has a significant change in status, it is the day of the significant change and the day after the significant change.**

Signatures of Clinicians who Completed a Portion of the Accompanying Assessment

I certify, to the best of my knowledge, the information in this assessment is

- collected in accordance with the guidelines provided by CMS for participation in this Post Acute Care Payment Reform Demonstration,
- an accurate and truthful reflection of assessment information for this patient,
- based on data collection occurring on the dates specified, and
- data-entered accurately.

I understand the importance of submitting only accurate and truthful data.

- This facility's participation in the Post Acute Care Payment Reform Demonstration is conditioned on the accuracy and truthfulness of the information provided.
- The information provided may be used as a basis for ensuring that the patient receives appropriate and quality care and for conveying information about the patient to a provider in a different setting at the time of transfer.

I am authorized to submit this information by this facility on its behalf.

[I agree] [I do not agree]

	Name/Signature	**Credential**	**License # (if required)**	**Sections Worked On**	**Date(s) of Data collection**
	(Joe Smith)	(RN)	(MA000000)	Medical Information	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

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 0938-1037. The time required to complete this information collection is estimated to average one hour or less 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. Expiration Date: 03/31/2011.

I. Administrative Items

A. Assessment Type

Enter Code [ ]

A1. Reason for assessment
1. **Acute discharge**
2. **PAC admission**
3. **PAC discharge**
4. **Interim**
5. **Expired**

A3. Assessment Reference Date

_____/_____/_____
MM DD YYYY

B. Provider Information

B1. Provider's Name

C. Patient Information

C1. Patient's First Name

C2. Patient's Middle Initial or Name

C3. Patient's Last Name

C4. Patient's Nickname (Optional)

C5. Patient's Medicare Health Insurance Number

|___|___|___|___|___|___|___|___|___|___|___|___|

C6. Patient's Medicaid Number

|___|___|___|___|___|___|___|___|___|___|

C8a. Admission Date

_____/_____/_____
MM DD YYYY

C8b. Birth Date

_____/_____/_____
MM DD YYYY

Enter Code [ ]

C10. Gender
1. **Male**
2. **Female**

D. Payer Information: Current Payment Source(s)

Check all that apply.

- [ ] **D1. None** (no charge for current services)
- [ ] **D2. Medicare** (traditional fee-for-service)
- [ ] **D3. Medicare** (HMO/managed care)
- [ ] **D4. Medicaid** (traditional fee-for-service)
- [ ] **D5. Medicaid** (HMO/managed care)
- [ ] **D6. Workers' compensation**
- [ ] **D7. Title programs** (e.g., Title III, V, or XX)
- [ ] **D8. Other government** (e.g., TRICARE, VA, etc.)
- [ ] **D9. Private insurance/Medigap**
- [ ] **D10. Private HMO/managed care**
- [ ] **D11. Self-pay**
- [ ] **D12. Other** (specify) ____________________
- [ ] **D13. Unknown**

T.I How long did it take you to complete the ***I. Administrative Items*** *section? ________ (minutes)*
Clinician Name(s) ____

III. Current Medical Information

Clinicians:

For this section, please provide a listing of medical diagnoses, comorbid diseases and complications, and procedures based on a review of the patient's clinical records available at the time of assessment. This information is intended to enhance continuity of care.

A. Primary and Other Diagnoses, Comorbidities, and Complications

Indicate the primary diagnosis and up to 14 other diagnoses being treated, managed, or monitored in this setting. Please include all diagnoses (e.g., depression, schizophrenia, dementia, protein calorie malnutrition).

A1. Primary Diagnosis at Assessment ____

B. Other Diagnoses, Comorbidities, and Complications (Optional)

B1a.	
B2a.	
B3a.	
B4a.	
B5a.	
B6a.	
B7a.	
B8a.	
B9a.	
B10a.	
B11a.	
B12a.	
B13a.	
B14a.	
Enter Code	**B15.** Is this list complete? **0. No** **1. Yes**

III. Current Medical Information (cont.)

C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions) (Optional)

Enter Code

C1. Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?
0. No *(If **No**, skip to Section D. Major Treatments.)*
1. Yes

List up to 15 procedures (diagnostic, surgical and therapeutic interventions). Indicate if a procedure was left, right, or not applicable (N/A). If procedure was bilateral (e.g., bilateral knee replacement), check both left and right boxes.

Procedure		Left	Right	N/A
C1a.		**C1b.**	**C1c.**	**C1d.**
C2a.		**C2b.**	**C2c.**	**C2d.**
C3a.		**C3b.**	**C3c.**	**C3d.**
C4a.		**C4b.**	**C4c.**	**C4d.**
C5a.		**C5b.**	**C5c.**	**C5d.**
C6a.		**C6b.**	**C6c.**	**C6d.**
C7a.		**C7b.**	**C7c.**	**C7d.**
C8a.		**C8b.**	**C8c.**	**C8d.**
C9a.		**C9b.**	**C9c.**	**C9d.**
C10a.		**C10b.**	**C10c.**	**C10d.**
C11a.		**C11b.**	**C11c.**	**C11d.**
C12a.		**C12b.**	**C12c.**	**C12d.**
C13a.		**C13b.**	**C13c.**	**C13d.**
C14a.		**C14b.**	**C14c.**	**C14d.**
C15a.		**C15b.**	**C15c.**	**C15d.**

Enter Code

C16. Is this list complete?
0. No
1. Yes

III. Current Medical Information (cont.)

D. Major Treatments

Which of the following treatments did the patient receive?

Check all that apply.

Used Within Two Days of the Interim Period:	
D1b. ☐	**D1. None**
D2b. ☐	**D2. Insulin Drip**
D3b. ☐	**D3. Total Parenteral Nutrition**
D4b. ☐	**D4. Central Line Management**
D5b. ☐	**D5. Blood Transfusion(s)**
D6b. ☐	**D6. Controlled Parenteral Analgesia – Peripheral**
D7b. ☐	**D7. Controlled Parenteral Analgesia – Epidural**
D8b. ☐	**D8. Left Ventricular Assistive Device** (LVAD)
D9b. ☐	**D9. Continuous Cardiac Monitoring** ***D9c.*** *Specify reason for continuous monitoring:* ____________________
D10b. ☐	**D10. Chest Tube(s)**
D11b. ☐	**D11. Trach Tube with Suctioning** ***D11c.*** *Specify most intensive frequency of suctioning during stay:* *Every____ hours*
D12b. ☐	**D12. High O2 Concentration Delivery System with FiO2 > 40%**
D13b. ☐	**D13. Non-invasive ventilation**
D14b. ☐	**D14. Ventilator – Weaning**
D15b. ☐	**D15. Ventilator – Non-Weaning**
D16b. ☐	**D16. Hemodialysis**
D17b. ☐	**D17. Peritoneal Dialysis**
D18b. ☐	**D18. Fistula or Other Drain Management**
D19b. ☐	**D19. Negative Pressure Wound Therapy**
D20b. ☐	**D20. Complex Wound Management** with positioning and skin separation/traction that requires at least two persons
D21b. ☐	**D21. Halo**
D22b. ☐	**D22. Complex External Fixators** (e.g., Ilizarov)
D23b. ☐	**D23. One-on-One 24-Hour Supervision** ***D23c.*** *Specify reason for 24-hour supervision:* _______________________
D24b. ☐	**D24. Specialty Surface or Bed** (i.e., air fluidized, bariatric, low air loss, or rotation bed)
D25b. ☐	**D25. Multiple IV Antibiotic Administration**
D26b. ☐	**D26. IV Vaso-actors** (e.g., pressors, dilators, medication for pulmonary edema)
D27b. ☐	**D27. IV Anti-coagulants**
D28b. ☐	**D28. IV Chemotherapy**
D29b. ☐	**D29. Indwelling Bowel Catheter Management System**
D30b. ☐	**D30. Other Major Treatments** ***D30c.*** *Specify*____

III. Current Medical Information (cont.)

E. Medications (Optional)

List all current medications for the patient.

Medication Name	Dose	Route	Frequency	Planned Stop Date (if applicable)
E1a.__________	E1b.__________	E1c.__________	E1d.__________	E1e.___/___/___
E2a.__________	E2b.__________	E2c.__________	E2d.__________	E2e.___/___/___
E3a.__________	E3b.__________	E3c.__________	E3d.__________	E3e.___/___/___
E4a.__________	E4b.__________	E4c.__________	E4d.__________	E4e.___/___/___
E5a.__________	E5b.__________	E5c.__________	E5d.__________	E5e.___/___/___
E6a.__________	E6b.__________	E6c.__________	E6d.__________	E6e.___/___/___
E7a.__________	E7b.__________	E7c.__________	E7d.__________	E7e.___/___/___
E8a.__________	E8b.__________	E8c.__________	E8d.__________	E8e.___/___/___
E9a.__________	E9b.__________	E9c.__________	E9d.__________	E9e.___/___/___
E10a.__________	E10b.__________	E10c.__________	E10d.__________	E10e.___/___/___
E11a.__________	E11b.__________	E11c.__________	E11d.__________	E11e.___/___/___
E12a.__________	E12b.__________	E12c.__________	E12d.__________	E12e.___/___/___
E13a.__________	E13b.__________	E13c.__________	E13d.__________	E13e.___/___/___
E14a.__________	E14b.__________	E14c.__________	E14d.__________	E14e.___/___/___
E15a.__________	E15b.__________	E15c.__________	E15d.__________	E15e.___/___/___
E16a.__________	E16b.__________	E16c.__________	E16d.__________	E16e.___/___/___
E17a.__________	E17b.__________	E17c.__________	E17d.__________	E17e.___/___/___
E18a.__________	E18b.__________	E18c.__________	E18d.__________	E18e.___/___/___
E19a.__________	E19b.__________	E19c.__________	E19d.__________	E19e.___/___/___
E20a.__________	E20b.__________	E20c.__________	E20d.__________	E20e.___/___/___
E21a.__________	E21b.__________	E21c.__________	E21d.__________	E21e.___/___/___
E22a.__________	E22b.__________	E22c.__________	E22d.__________	E22e.___/___/___
E23a.__________	E23b.__________	E23c.__________	E23d.__________	E23e.___/___/___
E24a.__________	E24b.__________	E24c.__________	E24d.__________	E24e.___/___/___
E25a.__________	E25b.__________	E25c.__________	E25d.__________	E25e.___/___/___
E26a.__________	E26b.__________	E26c.__________	E26d.__________	E26e.___/___/___
E27a.__________	E27b.__________	E27c.__________	E27d.__________	E27e.___/___/___
E28a.__________	E28b.__________	E28c.__________	E28d.__________	E28e.___/___/___
E29a.__________	E29b.__________	E29c.__________	E29d.__________	E29e.___/___/___
E30a.__________	E30b.__________	E30c.__________	E30d.__________	E30e.___/___/___

Enter Code [ ]

E31. Is this list complete?

0. No
1. Yes

For Future Use

III. Current Medical Information (cont.)

G. Skin Integrity (Complete during the 2-day assessment period.)

G1-2. PRESENCE OF PRESSURE ULCERS

Enter Code		Enter Code	
[ ]	**G1.** Is this patient at **risk of developing pressure ulcers**? **0. Respond at a later date.** **1. No** **2. Yes, indicated by clinical judgment** **3. Yes, indicated high risk by formal assessment** (e.g., on Braden or Norton tools) **or the patient has a stage 1 or greater ulcer, a scar over a bony prominence, or a non-removable dressing, device, or cast.**	[ ]	**G2.** Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher or unstageable? **0. No** *(If **No**, skip to G5. Major Wounds.)* **1. Yes**

IF THE PATIENT HAS ONE OR MORE STAGE 2-4 PRESSURE ULCERS, indicate the number of **unhealed pressure ulcers at each stage**.

CODING:	Number present at assessment	Number with onset during this service	Pressure ulcer at stage 2, stage 3, or stage 4 only:
Please specify the number of ulcers at each stage: **0 = 0 ulcers** **1 = 1 ulcer** **2 = 2 ulcers** **3 = 3 ulcers** **4 = 4 ulcers** **5 = 5 ulcers** **6 = 6 ulcers** **7 = 7 ulcers** **8 = 8 or more ulcers** **9 = Unknown**	Stage 2 Enter [ ] Code	Stage 2 Enter [ ] Code	**G2a. Stage 2** – Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister (excludes those resulting from skin tears, tape stripping, or incontinence associated dermatitis).
	Stage 3 Enter [ ] Code	Stage 3 Enter [ ] Code	**G2b. Stage 3** – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
	Stage 4 Enter [ ] Code	Stage 4 Enter [ ] Code	**G2c. Stage 4** – Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
	Unstageable Enter [ ] Code	Unstageable Enter [ ] Code	**G2d. Unstageable** – Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, gray, green, or brown) or eschar (tan, brown, or black) in the wound bed. Include ulcers that are **known or likely**, but are not stageable due to non-removable dressing, device, cast or suspected deep tissue injury in evolution.

III. Current Medical Information (cont.)

G. Skin Integrity (Complete during the 2-day assessment period.) (cont.)

Number of Unhealed Stage 2 Ulcers ☐

G2e. Number of unhealed stage 2 ulcers known to be present for more than 1 month.

If the patient has one or more unhealed stage 2 pressure ulcers, record the number present today that were first observed **more than 1 month ago**, according to the best available records. If the patient has no unhealed stage 2 pressure ulcers, record “0.”

G3. If any pressure ulcer is stage 3 or 4 (or if eschar is present), record the most recent measurements for the LARGEST ulcer (or eschar):

Enter Length |___|___|.|___|cm

a. Longest length in any direction

Enter Width |___|___|.|___|cm

b. Width of SAME unhealed ulcer or eschar

Date Measured ____/____/____ (MM DD YYYY)

c. Date of measurement

Enter Code ☐

G4. Indicate if any unhealed stage 3 or stage 4 pressure ulcer(s) has undermining and/or tunneling (sinus tract) present.

0. No
1. Yes
8. Unable to assess

G5. MAJOR WOUND (excluding pressure ulcers)

Enter Code ☐

Does the patient have one or more **major wound(s)** that require ongoing care because of draining, infection, or delayed healing?

0. No *(If **No**, skip to G6. Turning Surfaces Not Intact.)*
1. Yes

G5a–e. NUMBER OF MAJOR WOUNDS

Number of Major Wounds	Type(s) of Major Wound(s)
☐☐	**G5a. Delayed healing of surgical wound**
☐☐	**G5b. Trauma-related wound**
☐☐	**G5c. Diabetic foot ulcer(s)**
☐☐	**G5d. Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot)**
☐☐	**G5e. Other** (e.g., incontinence associated dermatitis, normal surgical wound healing). Please specify: ________________

G6. TURNING SURFACES NOT INTACT

Check all that apply.

Turning Surface	Indicate which of the following turning surfaces have either a pressure ulcer or major wound.
☐	**a. Skin for all turning surfaces is intact**
☐	**b. Right hip not intact**
☐	**c. Left hip not intact**
☐	**d. Back/buttocks not intact**
☐	**e. Other turning surface(s) not intact**

III. Current Medical Information (cont.)

H. Physiologic Factors (Complete during the 2-day assessment period.)

Record the most recent value for each of the following physiologic factors tested during this admission. Indicate the date (MM/DD/YYYY) that the value was collected. If the test was not provided during this admission, check "not tested." If it is not possible to measure the height and weight, check box if value is estimated (actual measurement is preferred).

Date	Complete using format below	Value	Check if NOT tested	Check here if value is estimated	Anthropometric Measures
H1a. __/__/__	xxx.x	H1b. ____	H1c. ☐	H1d. ☐	H1. Height (inches) OR
H2a. __/__/__	xxx.x	H2b. ____	H2c. ☐	H2d. ☐	H2. Height (cm)
H3a. __/__/__	xxx.x	H3b. ____	H3c. ☐	H3d. ☐	H3. Weight (pounds) OR
H4a. __/__/__	xxx.x	H4b. ____	H4c. ☐	H4d. ☐	H4. Weight (Kg)
					Vital Signs
H5a. __/__/__	xxx.x	H5b. ____	H5c. ☐		H5. Temperature (°F) OR
H6a. __/__/__	xx.x	H6b. ____	H6c. ☐		H6. Temperature (°C)
H7a. __/__/__	xxx	H7b. ____	H7c. ☐		H7. Heart Rate (beats/min)
H8a. __/__/__	xx	H8b. ____	H8c. ☐		H8. Respiratory Rate (breaths/min)
H9a. __/__/__	xxx/xxx	H9b. ____	H9c. ☐		H9. Blood Pressure mm/Hg
H10a. __/__/__	xxx	H10b. ____	H10c. ☐		H10. O_2 saturation (Pulse Oximetry) %
					H10d. *Please specify source and amount of supplemental O_2* ________
					Laboratory
H11a. __/__/__	xx.x	H11b. ____	H11c. ☐		H11. Hemoglobin (gm/dL)
H12a. __/__/__	xx.x	H12b. ____	H12c. ☐		H12. Hematocrit (%)
H13a. __/__/__	xxx.x	H13b. ____	H13c. ☐		H13. WBC (K/mm^3)
H14a. __/__/__	xx.x	H14b. ____	H14c. ☐		H14. HbA1c (%)
H15a. __/__/__	xxx	H15b. ____	H15c. ☐		H15. Sodium (mEq/L)
H16a. __/__/__	x.x	H16b. ____	H16c. ☐		H16. Potassium (mEq/L)
H17a. __/__/__	xx	H17b. ____	H17c. ☐		H17. BUN (mg/dL)
H18a. __/__/__	x.x	H18b. ____	H18c. ☐		H18. Creatinine (mg/dL)
H19a. __/__/__	x.x	H19b. ____	H19c. ☐		H19. Albumin (gm/dL)
H20a. __/__/__	xx.x	H20b. ____	H20c. ☐		H20. Prealbumin (mg/dL)
H21a. __/__/__	x.x	H21b. ____	H21c. ☐		H21. INR
					Other
H22a. __/__/__	xx	H22b. ____	H22c. ☐		H22. Left Ventricular Ejection Fraction (%) (This or prior setting acceptable.)
H23a. __/__/__			H23c. ☐		**Arterial Blood Gases (ABGs)**
					H23d. *Please specify source and amount of supplemental O_2* ________
H24.	x.xx	H24b. ____	H24c. ☐		H24. pH
H25.	xxx	H25b. ____	H25c. ☐		H25. PaCO2 (mm/Hg)
H26.	xxx	H26b. ____	H26c. ☐		H26. HCO3 (mEq/L)
H27.	xxx	H27b. ____	H27c. ☐		H27. PaO2 (mm/Hg)
H28.	xx	H28b. ____	H28c. ☐		H28. SaO2 (%)
H29.	xx	H29b. ____	H29c. ☐		H29. B.E. (base excess) (mEq/L)
H30a. __/__/__			H30c. ☐		**Pulmonary Function Tests**
H31.	x.xx	H31b. ____	H31c. ☐		H31. FVC (liters)
H32.	xx	H32b. ____	H32c. ☐		H32. FEV1% or FEV1/FVC (%)
H33.	x.xx	H33b. ____	H33c. ☐		H33. FEV1 (liters)
H34.	x.xx	H34b. ____	H34c. ☐		H34. PEF (liters per minute)
H35.	xxx	H35b. ____	H35c. ☐		H35. MVV (liters per minute)
H36.	x.xx	H36b. ____	H36c. ☐		H36. TLC (liters)
H37.	x.xx	H37b. ____	H37c. ☐		H37. FRC (liters)
H38.	x.xx	H38b. ____	H38c. ☐		H38. RV (liters)
H39.	x.xx	H39b. ____	H39c. ☐		H39. ERV (liters)

*T.III How long did it take you to complete the **III. Current Medical Information** section?* ________ *(minutes)*

Clinician Name(s) ________________________________

IV. Cognitive Status, Mood & Pain

G. Pain (Complete during the 2-day assessment period.)

Enter Code [ ]

G1. Pain Interview Attempted?

0. No *(If **No**, skip to G6. Pain Observational Assessment.)*
1. Yes

Enter Code [ ]

G2. Pain Presence

Ask patient: *"Have you had pain or hurting at any time during the last 2 days?"*

0. No *(If **No**, skip to Section V. Impairments.)*
1. Yes
8. Unable to answer or no response
skip to G6. Pain Observational Assessment.

Enter Code [ ]

G3. Pain Severity

Ask patient: *"Please rate your worst pain during the last 2 days on a zero to 10 scale, with zero being no pain and 10 as the worst pain you can imagine."*

Enter 88 if patient does not answer or is unable to respond and *skip to G6. Pain Observational Assessment.*

Enter Code [ ]

G4. Pain Effect on Sleep

Ask patient: *"During the past 2 days, has pain made it hard for you to sleep?"*

0. No
1. Yes
8. Unable to answer or no response

Enter Code [ ]

G5. Pain Effect on Activities

Ask patient: *"During the past 2 days, have you limited your activities because of pain?"*

0. No
1. Yes
8. Unable to answer or no response

G6. Pain Observational Assessment. If patient could not be interviewed for pain assessment, check all indicators of pain or possible pain.

Check all that apply.

- [ ] **G6a. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- [ ] **G6b. Vocal complaints of pain** (e.g., "that hurts, ouch, stop")
- [ ] **G6c. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- [ ] **G6d. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- [ ] **G6e. None** of these signs observed or documented

*T.IV How long did it take you to complete the **IV. Cognitive Status, Mood & Pain** section? ______ (minutes)*
Clinician Name(s) ____________________

V. Impairments

A. Bladder and Bowel Management: Use of Device(s) and Incontinence (Complete during the 2-day assessment period.)

Enter Code [ ]

A1. Does the patient have any impairments with bladder or bowel management (e.g., use of a device or incontinence)?
- **0. No** *(If **No** impairments, skip to Section B. Swallowing.)*
- **1. Yes** *(If **Yes**, please complete this section.)*

Bladder	Bowel	
A2a. Enter Code [ ]	**A2b.** Enter Code [ ]	**A2.** Does this patient use an **external or indwelling device** or require intermittent catheterization? **0. No** **1. Yes**
A3a. Enter Code [ ]	**A3b.** Enter Code [ ]	**A3.** Indicate the **frequency of incontinence**. **0. Continent** (no documented incontinence) **1. Stress incontinence only** (bladder only) **2. Incontinent less than daily** **3. Incontinent daily** (at least once a day) **4. Always incontinent** **5. No urine/bowel output** (e.g., renal failure)
A4a. Enter Code [ ]	**A4b.** Enter Code [ ]	**A4.** Does the patient **need assistance** to manage equipment or devices related to bladder or bowel care (e.g., urinal, bedpan, indwelling catheter, intermittent catheterization, ostomy, incontinence pads/undergarments)? **0. No** **1. Yes**
A5a. Enter Code [ ]	**A5b.** Enter Code [ ]	**A5.** If the patient is incontinent or has an indwelling device, was the patient incontinent (excluding stress incontinence) immediately prior to the current illness, exacerbation, or injury? **0. No** **1. Yes** **9. Unknown**

B. Swallowing (Complete during the 2-day assessment period.)

Check all that apply.

B1. Does the patient have any signs or symptoms of a possible swallowing disorder?

- [ ] **B1a. Complaints of difficulty or pain with swallowing**
- [ ] **B1b. Coughing or choking during meals or when swallowing medications**
- [ ] **B1c. Holding food in mouth/cheeks or residual food in mouth after meals**
- [ ] **B1d. Loss of liquids/solids from mouth when eating or drinking**
- [ ] **B1e. NPO: intake not by mouth**
- [ ] **B1f. Other** (specify) ____________________
- [ ] **B1g. None**

Enter Code [ ]

B2. Describe the patient's usual ability with swallowing.
- **3. Regular food:** Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.
- **2. Modified food consistency/supervision:** Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.
- **1. Tube/parenteral feeding:** Tube/parenteral feeding used wholly or partially as a means of sustenance.

V. Impairments (cont.)

C. Hearing, Vision, and Communication (Complete during the 2-day assessment period.)

Enter Code [ ]

C1. Does the patient have any impairments with hearing, vision, or communication?
- **0. No** *(If **No** impairments, skip to Section D. Weight-bearing.)*
- **1. Yes** *(If **Yes**, please complete this section.)*

C1a. Understanding Verbal Content (excluding language barriers)

Enter Code [ ]

4. **Understands:** Clear comprehension without cues or repetitions
3. **Usually Understands:** Understands most conversations, but misses some part/intent of message. Requires cues at times to understand
2. **Sometimes Understands:** Understands only basic conversations or simple, direct phrases. Frequently requires cues to understand
1. **Rarely/Never Understands**
8. **Unable to assess**
9. **Unknown**

C1b. Expression of Ideas and Wants

Enter Code [ ]

4. Expresses complex messages **without difficulty** and with speech that is clear and easy to understand
3. Exhibits some **difficulty** with expressing needs and ideas (e.g., some words or finishing thoughts) or speech is not clear
2. **Frequently** exhibits difficulty with expressing needs and ideas
1. **Rarely/Never** expresses self or speech is very difficult to understand.
8. **Unable to assess**
9. **Unknown**

C1c. Ability to See in Adequate Light (with glasses or other visual appliances)

Enter Code [ ]

3. **Adequate:** Sees fine detail, including regular print in newspapers/books
2. **Mildly to Moderately Impaired:** Can identify objects; may see large print
1. **Severely Impaired:** No vision or object identification questionable
8. **Unable to assess**
9. **Unknown**

C1d. Ability to Hear (with hearing aid or hearing appliance, if normally used)

Enter Code [ ]

3. **Adequate:** Hears normal conversation and TV without difficulty
2. **Mildly to Moderately Impaired:** Difficulty hearing in some environments or speaker may need to increase volume or speak distinctly
1. **Severely Impaired:** Absence of useful hearing
8. **Unable to assess**
9. **Unknown**

D. Weight-bearing (Complete during the 2-day assessment period.)

Enter Code [ ]

D1. Does the patient have any impairments with weight-bearing?
- **0. No** *(If **No** impairments, skip to Section E.. Grip Strength.)*
- **1. Yes** *(If **Yes**, please complete this section.)*

CODING: Indicate all the patient's weight-bearing restrictions.

1. **Fully weight-bearing:** No medical restrictions
0. **Not fully weight-bearing:** Patient has medical restrictions or unable to bear weight (e.g. amputation)

Upper Extremity		Lower Extremity	
D1a. Left	**D1b. Right**	**D1c. Left**	**D1d. Right**
Enter Code [ ]	Enter Code [ ]	Enter Code [ ]	Enter Code [ ]

V. Impairments (cont.)

E. Grip Strength (Complete during the 2-day assessment period.)

Enter Code [ ]

E1. Does the patient have any impairments with grip strength?
0. No *(If **No** impairments, skip to Section F. Respiratory Status.)*
1. Yes *(If **Yes**, please complete this section.)*

CODING: Indicate the patient's ability to squeeze your hand.

2. **Normal**
1. **Reduced/Limited**
0. **Absent**

E1a. Left Hand	E1b. Right Hand
Enter Code [ ]	Enter Code [ ]

F. Respiratory Status (Complete during the 2-day assessment period.)

Enter Code [ ]

F1. Does the patient have any impairments with respiratory status?
0. No *(If **No** impairments, skip to Section G. Endurance.)*
1. Yes *(If **Yes**, please complete this section.)*

With Supplemental O_2	Without Supplemental O_2
Enter Code [ ]	Enter Code [ ]
F1a.	F1b.

Respiratory Status: Was the patient dyspneic or noticeably **short of breath**?

5. **Severe, with evidence the patient is struggling to breathe at rest**
4. **Mild at rest** (during day or night)
3. **With minimal exertion** (e.g., while eating, talking, or performing other ADLs) **or with agitation**
2. **With moderate exertion** (e.g., while dressing, using commode or bedpan, walking between rooms)
1. **When climbing stairs**
0. **Never, patient was not short of breath**
8. **Not assessed** (e.g., on ventilator)
9. **Not applicable**

G. Endurance (Complete during the 2-day assessment period.)

Enter Code [ ]

G1. Does the patient have any impairments with endurance?
0. No *(If **No** impairments, skip to Section H. Mobility Devices and Aids Needed.)*
1. Yes *(If **Yes**, please complete this section.)*

Enter Code [ ]

G1a. Mobility Endurance: Was the patient able to walk or wheel 50 feet (15 meters)?
0. **No, could not do**
1. **Yes, can do with rest**
2. **Yes, can do without rest**
8. **Not assessed due to medical restriction**

Enter Code [ ]

G1b. Sitting Endurance: Was the patient able to tolerate sitting for 15 minutes?
0. **No**
1. **Yes, with support**
2. **Yes, without support**
8. **Not assessed due to medical restriction**

V. Impairments (cont.)

H. Mobility Devices and Aids Needed (Complete during the 2-day assessment period.)

Check all that apply.

H1. Indicate all mobility devices and aids needed at time of assessment.

- ☐ a. **Canes/crutch**
- ☐ b. **Walker**
- ☐ c. **Orthotics/prosthetics**
- ☐ d. **Wheelchair/scooter full time**
- ☐ e. **Wheelchair/scooter part time**
- ☐ f. **Mechanical lift**
- ☐ g. **Other** (specify) ____________________
- ☐ h. **None apply**

*T.V How long did it take you to complete the **V. Impairments** section? ______ (minutes) Clinician Name(s) ____________________*

VI. Functional Status: Usual Performance

A. Core Self Care: The core self care items should be completed on ALL patients. (Complete during the 2-day assessment period.)

Code the patient's most usual performance using the 6-point scale below.

CODING:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** –Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

- **M.** Not attempted due to **medical condition**
- **S.** Not attempted due to **safety concerns**
- **A.** Task **attempted** but not completed
- **N.** **Not applicable**
- **P.** **Patient Refused**

Enter Code in Boxes ➔

Enter Code	Item
☐	**A1. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
☐	**A2. Tube feeding:** The ability to manage all equipment/supplies related to obtaining nutrition.
☐	**A3. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures: The ability to remove and replace dentures from and to mouth, and manage equipment for soaking and rinsing.
☐	**A4. Toilet hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment.
☐	**A5. Upper body dressing:** The ability to put on and remove shirt or pajama top. Includes buttoning three buttons.
☐	**A6. Lower body dressing:** The ability to dress and undress below the waist, including fasteners. Does not include footwear.

VI. Functional Status (cont.)

B. Core Functional Mobility: The core functional mobility items should be completed on ALL patients. (Complete during the 2-day assessment period.)

Complete for ALL patients: Code the patient's most usual performance using the 6-point scale below.

CODING:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** –Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

M. Not attempted due to **medical condition**
S. Not attempted due to **safety concerns**
A. Task **attempted** but not completed
N. Not applicable
P. Patient Refused

Enter Code in Boxes

Enter Code	Item
☐	**B1. Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.
☐	**B2. Sit to Stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
☐	**B3. Chair/Bed-to-Chair Transfer:** The ability to safely transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other.
☐	**B4. Toilet Transfer:** The ability to safely get on and off a toilet or commode.

MODE OF MOBILITY

Enter Code	Item
☐	**B5.** Does this patient primarily use a wheelchair for mobility? **0. No** *(If **No**, code B5a for the longest distance completed.)* **1. Yes** *(If **Yes**, code B5b for the longest distance completed.)*
	B5a. Select the longest distance the patient walks and code his/her level of independence (Level 1–6) on that distance. Observe performance. (Select only one.)
☐	**1. Walk 150 ft (45 m):** Once standing, can walk at least150 feet (45 meters) in corridor or similar space.
☐	**2. Walk 100 ft (30 m):** Once standing, can walk at least 100 feet (30 meters) in corridor or similar space
☐	**3. Walk 50 ft (15 m):** Once standing, can walk at least 50 feet (15 meters) in corridor or similar space
☐	**4. Walk in Room Once Standing:** Once standing, can walk at least 10 feet (3 meters) in room, corridor or similar space.
	B5b. Select the longest distance the patient wheels and code his/her level of independence (Level 1–6). Observe performance. (Select only one.)
☐	**1. Wheel 150 ft (45 m):** Once sitting, can wheel at least 150 feet (45 meters) in corridor or similar space.
☐	**2. Wheel 100 ft (30 m):** Once sitting, can wheel at least 100 feet (30 meters) in corridor or similar space
☐	**3. Wheel 50 ft (15 m):** Once sitting, can wheel at least 50 feet (15 meters) in corridor or similar space
☐	**4. Wheel in Room Once Seated:** Once seated, can wheel at least 10 feet (3 meters) in room, corridor, or similar space.

VI. Functional Status (cont.)

C. Supplemental Functional Ability (Complete during the 2-day assessment period.)

Enter Code [ ] **C. Following discharge, is it anticipated that the patient will need post-acute care to improve their functional ability or other types of personal assistance?**

0. No *(If **No**, skip to Section VII. Overall Plan of Care/Advance Care Directives.)*
1. Yes

Please code the patient on all activities they are able to participate in and which you can observe, or have assessed by other means, using the 6-point scale below.

CODING:
Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Code for the most usual performance in the 2-day assessment period.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:
- **M.** Not attempted due to **medical condition**
- **S.** Not attempted due to **safety concerns**
- **E.** Not attempted due to **environmental constraints**
- **A.** Task **attempted** but not completed
- **N. Not applicable**
- **P. Patient Refused**

→ Enter Code in Boxes →

Enter Code	Item
[ ]	**C1. Wash Upper Body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.
[ ]	**C2. Shower/bathe self:** The ability to bathe self in shower or tub, including washing, rinsing, and drying, self. Does not include transferring in/out of tub/shower.
[ ]	**C3. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
[ ]	**C4. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
[ ]	**C5. Picking up object:** The ability to bend/stoop from a standing position to pick up small object such as a spoon from the floor.
[ ]	**C6. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that are appropriate for safe mobility.
MODE OF MOBILITY	
[ ]	**C7.** Does this patient primarily use a wheelchair for mobility? **0. No** *(If **No**, code C7a–C7f.)* **1. Yes** *(If **Yes**, code C7f–C7h.)*
[ ]	**C7a. 1 step (curb):** The ability to step over a curb or up and down one step.
[ ]	**C7b. Walk 50 feet with two turns:** The ability to walk 50 feet and make two turns.
[ ]	**C7c. 12 steps-interior:** The ability to go up and down 12 interior steps with a rail.
[ ]	**C7d. Four steps-exterior:** The ability to go up and down 4 exterior steps with a rail.
[ ]	**C7e. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.
[ ]	**C7f. 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.
[ ]	**C7g. Wheel short ramp:** Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters).
[ ]	**C7h. Wheel long ramp:** Once seated in wheelchair, goes up and down a ramp of more than 12 feet (4 meters).

VI. Functional Status (cont.)

C. Supplemental Functional Ability (Complete during the 2-day assessment period.) (cont.)

Please code patient on all activities they are able to participate in and which you can observe, or have assessed by other means, using the 6-point scale below.

CODING:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Code for the most usual performance in the first 2-day assessment period.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
5. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
4. **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
3. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
2. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the task.

If activity was not attempted code:

- **M.** Not attempted due to **medical condition**
- **S.** Not attempted due to **safety concerns**
- **E.** Not attempted due to **environmental constraints**
- **A.** Task **attempted** but not completed
- **N. Not applicable**
- **P. Patient Refused**

➔ Enter Code in Boxes ➔

Enter Code	Item
[ ]	**C8. Telephone-answering:** The ability to pick up call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone.
[ ]	**C9. Telephone-placing call:** The ability to pick up and place call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone.
[ ]	**C10. Medication management-oral medications:** The ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
[ ]	**C11. Medication management-inhalant/mist medications:** The ability to prepare and take all prescribed inhalant/mist medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
[ ]	**C12. Medication management-injectable medications:** The ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
[ ]	**C13. Make light meal:** The ability to plan and prepare all aspects of a light meal such as a bowl of cereal or a sandwich and cold drink, or reheat a prepared meal.
[ ]	**C14. Wipe down surface:** The ability to use a damp cloth to wipe down surface such as table top or bench to remove small amounts of liquid or crumbs. Includes ability to clean cloth of debris in patient's customary manner.
[ ]	**C15. Light shopping:** Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.
[ ]	**C16. Laundry:** Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, and adding laundry detergent.
[ ]	**C17. Use public transportation:** The ability to plan and use public transportation. Includes boarding, riding, and alighting from transportation.

T.VI How long did it take you to complete the ***VI. Functional Status*** *section? ______ (minutes)*
Clinician Name(s) ____

VII. Overall Plan of Care/Advance Care Directives

A. Overall Plan of Care/Advance Care Directives

Enter Code [ ]

A1. Have the patient (or representative) and the care team (or physician) documented agreed-upon care goals and expected dates of completion or re-evaluation?

0. No, but this work is in process
1. Yes
9. Unclear or unknown

Enter Code [ ]

A2. Which description best fits the patient's overall status?

1. **The patient is stable with no risk for serious complications and death (beyond those typical of the patient's age).**
2. **The patient is temporarily facing high health risks but likely to return to being stable without risk for serious complications and death (beyond those typical of the patient's age).**
3. **The patient is likely to remain in fragile health and have ongoing high risks of serious complications and death.**
4. **The patient has serious progressive conditions that could lead to death within a year.**
9. **The patient's situation is unknown or unclear to the respondent.**

Check all that apply.

A3. In anticipation of serious clinical complications, has the patient made and documented care decisions?

[ ] **1. The patient has designated and documented a decision-maker (if the patient is unable to make decisions).**

[ ] **2. The patient (or surrogate) has made and documented a decision to forgo resuscitation.**

T.VII How long did it take you to complete the ***VII. Overall Plan of Care/Advance Care Directives*** *section? ______ (minutes)*
Clinician Name(s) ____

IX. Medical Coding Information

Coders:

For this section, please provide a listing of principal diagnosis, comorbid diseases and complications, and procedures based on a review of the patient's clinical records at the time of assessment or at the time of a significant change in the patient's status affecting Medicare payment.

A. Principal Diagnosis (Optional)

Indicate the **principal diagnosis for billing purposes**. **Indicate the ICD-9 CM code**. For **V-codes**, also indicate the medical diagnosis and associated ICD-9 CM code. Be as specific as possible.

A1. ICD-9 CM code for Principal Diagnosis at Assessment |___|___|___|.|___|___|	**A2. If Principal Diagnosis was a V-code, what was the ICD-9 CM code for the primary medical condition or injury being treated?** |___|___|___|.|___|___|
A1a. Principal Diagnosis at Assessment ______________________	**A2a. If Principal Diagnosis was a V-code, what was the primary medical condition or injury being treated?** ______________________

B. Other Diagnoses, Comorbidities, and Complications (Optional)

List up to 15 **ICD-9 CM codes** and associated diagnoses being treated, managed, or monitored in this setting. Include all diagnoses (e.g., depression, schizophrenia, dementia, protein calorie malnutrition). If a V-code is listed, also provide the **ICD-9 CM code** for the medical diagnosis being treated.

ICD-9 CM code		Diagnosis	
B1a.	|___|___|___|.|___|___|	**B1b.**	
B2a.	|___|___|___|.|___|___|	**B2b.**	
B3a.	|___|___|___|.|___|___|	**B3b.**	
B4a.	|___|___|___|.|___|___|	**B4b.**	
B5a.	|___|___|___|.|___|___|	**B5b.**	
B6a.	|___|___|___|.|___|___|	**B6b.**	
B7a.	|___|___|___|.|___|___|	**B7b.**	
B8a.	|___|___|___|.|___|___|	**B8b.**	
B9a.	|___|___|___|.|___|___|	**B9b.**	
B10a.	|___|___|___|.|___|___|	**B10b.**	
B11a.	|___|___|___|.|___|___|	**B11b.**	
B12a.	|___|___|___|.|___|___|	**B12b.**	
B13a.	|___|___|___|.|___|___|	**B13b.**	
B14a.	|___|___|___|.|___|___|	**B14b.**	
B15a.	|___|___|___|.|___|___|	**B15b.**	

Enter Code	
☐	**B16.** Is this list complete? **0. No** **1. Yes**

IX. Medical Coding Information (cont.)

C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions) (Optional)

Enter Code [ ]

C1. Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?
0. No *(If **No**, skip to Section X.)*
1. Yes

List up to 15 **ICD-9 CM codes** and associated procedures (diagnostic, surgical, and therapeutic interventions) performed during this admission.

ICD-9 CM Code		Procedure	
C2a.	|___|___|.|___|___|	**C2b.**	
C3a.	|___|___|.|___|___|	**C3b.**	
C4a.	|___|___|.|___|___|	**C4b.**	
C5a.	|___|___|.|___|___|	**C5b.**	
C6a.	|___|___|.|___|___|	**C6b.**	
C7a.	|___|___|.|___|___|	**C7b.**	
C8a.	|___|___|.|___|___|	**C8b.**	
C9a.	|___|___|.|___|___|	**C9b.**	
C10a.	|___|___|.|___|___|	**C10b.**	
C11a.	|___|___|.|___|___|	**C11b.**	
C12a.	|___|___|.|___|___|	**C12b.**	
C13a.	|___|___|.|___|___|	**C13b.**	
C14a.	|___|___|.|___|___|	**C14b.**	
C15a.	|___|___|.|___|___|	**C15b.**	
C16a.	|___|___|.|___|___|	**C16b.**	

Enter Code [ ]

C17. Is this list complete?
0. No
1. Yes

*T.IX How long did it take you to complete the **IX. Medical Coding Information** section? ______ (minutes)*
Clinician Name(s) ____

X. Other Useful Information

A. Is there other useful information about this patient that you want to add?

XI. Feedback

A. Notes

Thank you for your participation in this important project. So that we may improve the form for future use, please comment on any areas of concern or things you would change about the form.