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The Development and Testing of the Continuity Assessment Record and Evaluation (CARE) Item Set: Final Report on the Development of the CARE Item Set

Volume 1 of 3

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American Hospital Association (AHA)

Acute Long Term Hospital Association (ALTHA)

American Medical Rehabilitation Providers Association (AMPRA)

Commission on the Accreditation of Rehabilitation Facilities (CARF)

The Joint Commission (JCAHO)

Leading Age (Formerly the American Association of Homes and Services for the Aging)

National Association for Home Care (NAHC)

National Association of Long Term Hospitals (NALTH)

Visiting Nurse Association of America (VNAA)

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CONTENTS SUMMARY

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EXECUTIVE SUMMARY

ES.1 Background

The Continuity Assessment Record and Evaluation (CARE) Item Set was developed as part of the national Post-Acute Care Payment Reform Demonstration (PAC-PRD) mandated by Congress under the Deficit Reduction Act of 2005. The CARE item set is designed to standardize assessment of patients' medical, functional, cognitive, and social support status across acute and post-acute settings, including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs). The goal was to standardize the items used in each of the existing assessment tools while posing a minimal administrative burden to providers. The CARE item set incorporates findings from Centers for Medicare & Medicaid Services (CMS) efforts to update existing federal assessment tools, including results from the IRF-Patient Assessment Instrument (IRF-PAI) Quality Indicators study (Gage, Bernard, Constantine, et al., 2005) and the 2006 Recommendations for a Uniform Patient Assessment for Post Acute Care (Kramer and Holthaus, 2006), suggested changes from the update of the Minimum Data Set (MDS) and the Outcome and Assessment Information Set (OASIS), and other measurement initiatives related to geriatric care.

One-third of all Medicare hospital patients are discharged to post-acute care settings (Gage, Morley, and Green, 2007). Since each setting uses a different assessment tool to measure patient severity and functional impairment levels, measuring effectiveness or comparing outcomes for patients is difficult. Acute hospitals, both general and LTCHs, each use their own assessment tools when a patient is admitted. IRFs, SNFs, and HHAs each use their respective federally mandated tools, including the IRF-PAI, the SNF Minimum Data Set (MDS 3.0), and the HH Outcome and Assessment Information Set (OASIS-C).[1] While these tools measure similar concepts, specific items differ across systems, and these differences reduce the ability to compare patient acuity, outcomes, and costs across settings. Medicare payments may vary substantially for similar patients in different PAC settings with little evidence that this payment difference translates into significant benefits for beneficiaries. In addition, little empirical evidence is available regarding outcomes differences across PAC settings; as a result, differences in quality of care for Medicare beneficiaries may go unrecognized.

This work addresses these issues by developing a standardized item set to measure patient conditions and impairment levels across settings. Similar efforts have been undertaken in the past but have failed because of a lack of consensus on the best measures to use in each setting or because of perceived burden for certain settings. This work addresses these issues by building on the current scientific evidence in each area, using a flexible item set that can change as medicine changes, and incorporating stakeholder input throughout the process. The CARE item set is a dynamic framework for a standard set of measures that can be made available through an item library. This will ensure standard items are used while allowing providers to vary in the domains they measure. The CARE item set contains two types of items: a core set to ask of any beneficiary receiving treatment and a supplemental set of additional standardized items specific

[1] At the time this work was under way, the MDS 2.0 and OASIS-B instruments were in use.

to various types of conditions. These supplemental items provide more granular measurement of severity for those who have a condition. By standardizing the language that clinicians use across sites of care, advances can be gained in measuring acuity, outcomes, and treatment needs, as well as improving information transfers between settings.

ES.2 Study Methods and Development of the CARE Item Set

The CARE item set was developed over a period of 14 months. The CARE effort created standardized assessment items based on the science behind the currently mandated assessment items in the Medicare payment systems—including those in the IRF-PAI, MDS, and OASIS instruments—and used only items related to patient severity, payment, or monitoring quality of care. Items from the existing MDS and OASIS tools that were used only for care planning were excluded from CARE. Most of the items in CARE are typically recorded in patient charts, though the format or formality of the record, location of the data in the record, and individual(s) or clinician(s) designated to collect the data may vary.

The development work aimed to build on contemporary scientific knowledge, to incorporate guidance provided by the five different measurement and clinical communities, and to minimize provider burden in collecting the data. Items were evaluated and selected to maximize reliability, validity, and breadth of application (to minimize floor and ceiling effects) and to minimize incentives that might encourage provider behavior inconsistent with best practices for care.

ES.2.1 Stakeholder Input

The development of CARE was a multipronged effort that elicited extensive input from numerous stakeholders, experts, clinical groups, and information technology experts. RTI worked closely with CMS to address the needs of quality, payment, research, survey, and certification. Key stakeholders from the five different research and clinical communities associated with acute and post-acute care services identified the core set of items needed to measure patient complexity that were also applicable in all sites of care. Input was collected through numerous stakeholder meetings, including several open door forums (ODFs) and technical expert panels (TEPs), as well as smaller, ongoing discussions with members of national provider associations. CMS invited provider associations from each of the five levels of care to nominate participants for different TEPs. The first TEP was tasked with defining the most important concepts in measuring differences in patient severity or factors that affect resource needs and outcomes in their respective populations. The second TEP included measurement experts from each of the five provider communities who discussed the best ways to measure the concepts proposed by the first TEP across settings. Pilot testing evaluated proposed items and the data collection process in each of the five levels of care. The resulting data were presented to a third TEP to further refine the proposed item set.

RTI established and published an e-mail box to allow providers, clinicians, and other individuals to submit comments on the content of the item set. Many of the national associations published the address for submitting comments and invited their members to do so. These comments informed the clinical workgroup's efforts. RTI and CMS sought feedback, particularly on the relative ease of completing each item within each provider population and on practical considerations such as training sessions and the Web-based data entry/submission

system. Operational feasibility was another important feature: while IRFs, SNFs, and HHAs already had procedures in place to submit their assessment tools to CMS, general acute hospitals and LTCHs did not. Clinical input also led to refinements of the online user experience. Two ODFs were held, in December 2006 and July 2007, to provide information on the demonstration and to invite input on the instrument's development.

ES.2.2 Defining the Domains

The first step in developing the CARE item set was to examine the domains common to each existing assessment tool and determine which types of concepts should be included in this standardized item set. The item set needed to effectively measure patient severity factors that would predict the need for different types of treatments, resources, or measure outcomes. Based on the 2006 report *Uniform Patient Assessment for Post Acute Care* (Kramer and Holthaus, 2006), five primary domains were selected. The first four domains—medical, functional, cognitive, and social support—are common to most medical assessment tools regardless of site of care. The fifth domain—transition items—was identified as important for improving quality of care. By improving information transfer between sites, avoidable hospitalizations and other adverse conditions can be prevented. Providers from all levels of acute and post-acute care were involved in identifying the necessary items.

The first four domains were identified as key to distinguishing different resource needs in each setting and identifying potential outcomes. Each domain has a small set of core items applicable to all patients and a set of supplemental items for patients with more specific needs. The majority of items are supplemental and used to measure severity of a condition only if a condition is present. Hence, not all factors are assessed on all patients, but those that are relevant are collected in a standard way. These four domains include the following:

- **Medical Status/Clinical Complexity.** These items measure patient medical status and include factors defining complexity in terms of medical diagnoses, resource use such as procedures or major treatments received during stay (e.g., ventilator weaning or hemodialysis), medications, skin integrity (number and size of pressure ulcers and locations and presence of other wounds), and physiologic factors (e.g., vital signs, laboratory results, blood gases, pulmonary function).
- **Functional Status.** These items include screening items on impairments (e.g., bladder, bowel, swallowing, vision, hearing, weight-bearing, grip strength, respiratory status, and endurance), as well as measures of self-care, mobility, and safety-related functions (medication management, phone management), and other items relevant to less impaired populations.
- **Cognitive Status.** These items target memory/recall ability, delirium/confusion (acute or chronic), behavioral symptoms including those that are self-injurious or directed toward others, signs of depression or sadness, and presence of pain, all of which may affect patients' engagement and outcomes.
- **Social Support Factors**. These items target social support issues, including information on structural barriers in the home, living situations, caregiver availability, and the need for assistance, as well as issues related to discharge complications.

Together, these four domains provide a comprehensive overview of a patient. For healthier patients, fewer items are relevant. For more complex patients, the CARE items offer standardized versions of information already collected on those types of patients. The fifth domain, transition items, included items that are important for the transfer of information between facilities but were not otherwise captured, such as information on allergies.

ES.2.3 Forming Clinical Workgroups

The initial RTI work was done by a large team of clinical staff from various backgrounds, including geriatric medicine, pulmonology, infectious disease, internal medicine, physiatry, medical and rehabilitation nursing, occupational therapy, physical therapy, epidemiology, intensive care, and public policy. Team members included staff from RTI, as well as subcontractors from the Rehabilitation Institute of Chicago, Evanston Northwestern Hospital/National Institutes of Health (NIH), Patient Reported Outcomes Measurement Information System (PROMIS) team, and Northwestern University, and consultants from the University of Pennsylvania, Case Western University, RAND/VA, and the Visiting Nurse Service of New York. Extensive input was also provided by our pilot test sites, including RML Specialty Hospital, Edwards Hospital, Rush Copley Hospital, Marianjoy Rehabilitation Hospital, ManorCare Corporation, and the Visiting Nurse Association of Fox Valley. Clinicians represented each of the five levels of care: acute, LTCH, IRF, SNF, and HHA.

Four clinical workgroups were established, each responsible for a different domain. (Care transitions were handled within the medical acuity group.) Representatives from all five levels of care participated in each workgroup. The clinical teams focused on item selection and the goal of each recommended item in preparing materials for later TEP review. Response burden was a constant criteria applied in each workgroup. The final list of items proposed to the TEPs was restricted to those measuring patient treatment needs or outcomes. Each item had to be justified for its inclusion in the CARE item set.

ES.2.4 Selecting Items for Use in the CARE Item Set

Although each of the current assessment tools measure similar concepts or subsets of concepts in each setting, they use different items to measure the concepts. The four workgroups were asked to identify the best items within each domain that could be applied across the range of health and impairment levels treated in these settings. The CARE items are the result of these discussions and represent standard measures of each concept. The workgroups received input and oversight throughout this process from the TEPs, provider and stakeholder input, and CMS review.

Many of the items that were considered for inclusion are the same as those in the MDS 3.0 and OASIS-C, because these two instruments were going through reevaluation at the same time and that work was done in collaboration with the development of the CARE item set. However, the CARE item set has many fewer items than the MDS or OASIS, because the two setting-specific tools also have care planning items that are not necessary for cross-setting measurement of severity.

The IRF-PAI tool was also used to identify important concepts or domains for measuring severity in populations needing physical rehabilitation services. Input from the field was used to

refine measurement approaches that both identified an impairment or level of independence and also improved measurement of function across populations. Similar inputs and revisions were based on recommendations from experts in the pressure ulcer measurement community, including the National Pressure Ulcer Advisory Panel and others. The CARE item set also has a few items that measure severity in the more medically complex populations treated in inpatient settings, such as acute hospitals, LTCHs, and IRFs. These items are based on those currently used in the acute and LTCH intake or assessment processes. Finally, certain factors were important for understanding discharge options and safety. These were based largely on the input of the home health and case management fields. The result is a standardized set of items able to collect medical, functional, cognitive, and discharge-related data in all post-acute settings.

As mentioned above, two types of items were included in the CARE item set in order to minimize provider burden—a core set to measure severity (or presence of a factor) on any patient receiving treatment and a supplemental set that provides standardized items to measure the severity of conditions when present. The core items provided a select set of data on patient medical complexity, functional impairment, and discharge status. The supplemental items provided standard language for measuring a set of items that refined the severity of conditions present. For example, all patients were assessed on the one screening item for pressure ulcer, but the rest of the pressure ulcer items measuring numbers and severity were only completed for those who had a stage 2 pressure ulcer or worse. Using a core/supplemental item approach allowed standardization of the language clinicians use across sites of care, while minimizing the number of items assessed on individual patients. Only the most complex patients were assessed on the total item set; the healthiest populations' assessments were limited to core items.

This first generation of CARE items targets basic core and supplemental items for measuring frequently occurring conditions in the Medicare populations, such as medical, surgical, and functional conditions. In the future, standardized subsets of CARE data, or modules that are more specific to a particular condition or provider setting, could be drawn from the registry storing the standardized CARE library of elements and concepts. This approach will allow item modules to be added in the future as more of the clinical items used in quality monitoring and survey and certification become integrated or, alternatively, allow items to be merged with other data sets. For example, the CARE data set could be merged to the MDS or OASIS files to incorporate care planning items associated with individual patients that are not relevant for payment or quality purposes. Additionally, standards-based items could be added to capture individual patient preferences for care treatments, along with items that measure the degree to which individuals' preferences and goals have been met. Thus, CARE has been designed to evolve over time to incorporate a broader range of items that address patient-centered care planning, quality measurement and reporting, and other emerging needs.

The CARE items were designed to be an interoperable item set that can change as medicine changes. The CARE vehicle contains HL7-based electronic components that will allow the exchange of data across different systems. CARE provides a dynamic framework for housing a standard set of items that can be used across the Medicare program, stored in an item library, and exchanged through interoperable data exchanges. Each item meets the national standards for health data exchanges as set by the Office of the National Coordinator. This framework will allow standard items to be used without requiring that all providers collect every item. By providing interoperable, standardized items, a national standard is in place that will

ease electronic transfers of data across providers and among authorized parties, such as the Medicare program.

ES.3 CARE Item Set Organization and Justifications

The result of the four clinical workgroups led to the development of a CARE item set that was used in two rounds of pilot tests. The results from the pilot test were used in TEPs and resulted in revised versions of the CARE item set that were subsequently published in the *Federal Register* for public comment.

In addition to the standardized items to measure each concept, the CARE item set also standardizes the assessment periods to define the window of time that reflects a patient's admission period or discharge period. Consistent assessment windows (e.g., "x days before or following hospital discharge") were needed to allow comparison of patient acuity at the same point in time, regardless of subsequent service sites. Currently, each mandated measurement system uses different assessment windows to describe patient severity. The IRF-PAI includes data collected during the first and last 3 days of a stay, the MDS collects admission data within the first 5 days of an admission and at subsequent follow-up times, and OASIS data are collected during the first visit, which may vary by when the HHA was able to initiate care, rather than reflect the patient at a specific time period following discharge from the hospital. As a result, each of the current systems may be assessing patients at different points in their episode, which will affect the severity ratings found in each tool. The CARE item set established standard assessment observation windows (time frames) across all five settings for time-sensitive data. The time frames used in CARE were 2-day assessment windows at admission and discharge. These observation windows could be extended by 1 day if the admission or discharge occurred after noon. For the home health setting, assessments were completed during the first and last visits. These observation windows were chosen to allow comparisons of clinical complexity, severity of illness, and functional status at specific points in time across provider settings.

The information collected was standardized within and between settings. Where appropriate, measures were also collected consistently between the admission and discharge forms to measure changes in clinical acuity or functional performance. At the same time, some items are only relevant at admission; others are important at discharge, especially if a patient is returning to the community. CARE items were selected with the goal of capturing patient acuity for the entire range of severity—from the patient about to be discharged from home health without any remaining concerns to the comatose patient.

One of the major changes made in the transition from MDS 2.0 to MDS 3.0 was the expansion of measures that directly captured the patient's voice through interviews or captured the patient's experience through direct observation of the patient's performance. The CARE item set also sought to capture the patient's voice in the items chosen for inclusion. Both patient self-report and clinical perceptions are included in the item set to the extent possible. The exact manner in which interview items were used in CARE was guided by input from the clinical communities.

ES.3.1 Administrative Items

The administrative section of the CARE tool consists of core items that identify the type of assessment and provide basic patient, provider, and payer information. Each of the administrative items is important for assuring quality and continuity of care during patient transitions. These items are based on current Medicare administrative data collection and related certification procedures.

ES.3.2 Admission Information Items

The admission information items provide baseline data on the patient's preadmission service use in the last 2 months; residential information, including type of residence prior to admission, whether they lived alone, and type of help used in the community setting; structural barriers at home; prior physical and cognitive functional status; use of assistive devices; and history of falls. The items in this section are collected for continuity of care purposes, as well as to highlight patient severity and to provide risk-adjustment measures for examining outcomes. Past service use provides important information about a patient's severity and potential resource utilization needs.

ES.3.3 Current Medical Information Items

The current medical items section of the CARE tool collects information on the reason for admission, including primary and other diagnoses, procedures, treatments, and physiologic factors. Some conditions, such as pressure ulcers and other major wounds, are included on the CARE tool due to their significant contribution to increased resource utilization, but are also important patient outcomes unto themselves. This section includes both core items, which are typically recorded on all patients in any setting, and supplemental items, which apply only to patients having certain conditions. Some items, such as primary and secondary conditions, are core measures of illness and are collected on every patient; other items, such as those under the major treatment section, are applicable only to patients having those more intensive treatments.

ES.3.4 Cognitive Status, Mood, and Pain Items

Stakeholder feedback to CMS underscored the importance of including patient-centered interview items that reflect the voice of the patient. The patient interview items included in this section of the CARE item set are important predictors of patient outcomes and resource utilization. This section measures patient abilities to interact with the clinicians, understand treatments, and, ultimately, achieve good outcomes. It contains both measures of cognition that are important for detecting problems, such as delirium or dementias that may be underreported, and other items that require patient interviews, such as pain presence and screening items for mood problems. Many of the items in this section are supplemental items to measure severity of problems once a core item identifies the presence of a problem.

The two domains of memory/recall and delirium were identified as important but not currently consistently measured in all five levels of care. Delirium was identified as particularly important to assess after transfer. The Confusion Assessment Method (CAM) included in the CARE item set has been previously tested in populations at different levels of care. The Brief Interview for Mental Status (BIMS) is a brief performance-based assessment that can be

administered by any trained clinician. The BIMS measure is used in the MDS 3.0 and has been found to be a strong measure of memory/recall for patients receiving skilled services. An observation-based assessment of cognitive status was included in the event of a patient's not being able to be interviewed.

This section of the CARE item set also includes self-report pain items. Self-report has been accepted as the most reliable source of data on pain; however, an observation-based item has been included for when a patient has difficulty with self-expression. Patients are asked to report their pain on the standard 0–10 scale used in most hospitals, LTCHs, and IRFs and also asked to report whether the pain limited their sleep or activities in the past 2 days. This approach allows for better measurement of pain effects across people who may have different pain thresholds. Clinicians complete either the interview or the observational item, although during the demonstration some clinicians suggested that both items should be completed on every patient.

Two measures of depression are included in this section. The first item is the two-item Patient Health Questionnaire (PHQ-2), which asks patients how often over the past 2 weeks they had low interest or were feeling sad. This item is a modified form of the longer MDS 3.0 item (PHQ-9). The second depression item is taken from the NIH/PROMIS initiative and asks patients to answer how often they felt sad in the past 2 weeks using a 5-level scale with "0" being never sad in the past 2 weeks and "5" being always sad.

ES.3.5 Impairment Items

Impairment items are important measures of patient severity and predictors of resource utilization. The impairments section contains a series of screening and supplemental items to identify any loss or abnormality across a set of potential impairments. Included are measures of impairment in the management of bladder and bowel; swallowing; hearing, vision, and communication; weight-bearing restrictions; grip strength; respiratory status; and mobility and sitting endurance. Additionally this section identifies the use of assistive devices, such as canes, walkers, wheelchairs, and other devices. These types of measures are commonly collected on populations with physical rehabilitation needs, and most are included in the federally mandated IRF-PAI, MDS, or OASIS tools. Most of the subsections under impairment include a screening item that would allow the majority of the section to be skipped for a relatively healthy patient with no impairment, therefore reducing provider burden.

ES.3.6 Functional Status Items

The CARE tool includes a core set of six self-care items and five functional mobility items that are asked of all patients. This core set of items will be used to evaluate all patients, regardless of functional level. These items include basic self-care activities such as eating, tube feeding, oral hygiene, toilet hygiene, and upper and lower body dressing. The items represent a range of difficulty. Including items with a broad range of difficulty is important for understanding the significant variation in functional status for patients in acute and post-acute care settings. Many of these items are based on the science behind existing items on the OASIS, MDS 3.0, IRF-PAI, and COCOA-B. Items capturing these concepts have been shown to work well and are easily scored. They also play a role clinically in discharge planning decisions.

CARE item text and structure were tailored to the range of patients that will be assessed using the CARE tool.

The core items are rated using a six-level rating scale measuring the patient's need for assistance. Rating scale levels include dependent, substantial/maximal assistance, partial/moderate assistance, supervision or touching assistance, setup or clean-up assistance, or independent. The primary purpose of each of the function items is to understand the potential resource needs as measured through the need for assistance scale. The CARE scale allows for better measurement of patients at the very impaired and very dependent levels by breaking out those who are totally dependent from those who can manage to complete a small amount of the task independently. This is important for patients in settings such as long-term care hospitals. Similarly, the CARE scale identifies the differences in resource needs between patients who need only setup assistance and those who need someone to provide supervision for safety or other reasons.

As in the medical section, these function items are divided into core measures of self-care and functional mobility needed to provide baseline information on all patients and supplemental items that will allow more refined measurement of patient ability, given the presence of a limitation in the core items. A wide range of activities was evaluated to address some of the ceiling and floor effects seen in functional performance measures used in the Functional Independence Measure (FIM®), MDS, and OASIS. For the demonstration, providers were instructed to collect functional information on all of the items with the goal of analyzing the patterns of functional performance within and between provider settings and potentially reducing the number of items needed to accurately assess functional ability in future versions.

ES.3.7 Overall Plan of Care/Advance Care Directive Items

Three items are included in this section that identify whether the clinical team has discussed treatment goals with the patient (or their representative), describe the overall prognosis in terms of patient stability and frailty, and identify whether the patient has made and documented future treatment decisions. These items are expected to improve quality of care for patients experiencing potentially life-threatening situations.

ES.3.8 Discharge Status Items

The items in the discharge status section of the CARE item set focus on patients' home situation, their need for assistance, and the availability of caregivers. The discharge status items also capture information that may affect their success at discharge, including assessments of their need for assistance with medications and transportation. This section of the item set also documents the potential post-acute care discharge settings that were considered by the clinical team, the availability of those services, the preference of patients or their families, and whether an option was covered by insurance. These are all factors likely to affect long-term outcomes.

The discharge care options section of the item set documents any provider that was considered potentially appropriate for discharge placement. Many factors lead to the choice of a post-acute care provider, so in addition to documenting whether the setting was deemed appropriate, this section documents if a bed was available in each setting considered, if the setting was refused by the patient or family, or if a setting was not covered by insurance. This

information will contribute to a better understanding of how post-acute care placement decisions are made. Additionally, this section of the CARE item set documents the date of discharge, the discharge location, and the name and identification number of the provider. Delays in discharge and reason for the delay are also noted in order to fully understand discharge options and placement.

ES.3.9 Discontinued Item Subsets: Engagement Items

One of the subsets investigated during pilot testing is not included in the final version of the CARE item set: engagement. The engagement subset was deleted because it had not been tested extensively on any population.

ES.4 Technical Expert Panels

Two TEP meetings were convened at CMS to gather input from the provider and research communities. The goal of these two panels was to collect expert input on the proposed framework and recommended items for the CARE item set. TEP members represented the range of the five types of providers expected to use the CARE item set, including practicing clinicians, providers, or associations representing care or provider certification. The second TEP comprised researchers with expertise in assessment instrument design, measurement, and payment policy in at least one of the five settings.

ES.4.1 Technical Expert Panel One Proceedings

The first TEP convened at CMS in Baltimore, Maryland, on March 6 and 7, 2007. The purpose of the TEP was to review the range of concepts that the clinical workgroups recommended as being important for explaining differences in resource utilization or monitoring patient outcomes and to discuss their applicability to the wide range of populations included in this effort.

At the conclusion of the TEP, panelists provided comments to summarize the concerns and recommendations made during the discussion. It was noted that the item set needed to have a user-friendly platform for completion and submission that burden for completion of the item set needed to be minimal and parsimonious, and that clear guidelines for use were needed. The item set needed to feature simple, streamlined language that would facilitate communication between settings during patient transfer while respecting the differences in settings. Although the item set is a living form, changes to the item set should be limited as much as possible due to resources spent training staff to complete the assessments. Finally, panelists said that the item set needed to be sensitive to the abilities of the workforce and to capture and address the diversity of both workforce and patients. Recommendations also included retaining core continuity of care items.

ES.4.2 Technical Expert Panel Two Proceedings

The second technical expert panel (TEP) convened at CMS in Baltimore, Maryland, on April 17 and 18, 2007. This panel comprised researchers and clinicians with expertise in assessment instrument design, measurement, and payment policy. The purpose of this TEP was to discuss key concepts necessary to allow the CARE item set to measure patient characteristics or predict resource utilization or patient outcomes. RTI and CMS provided TEP members with

background materials on item development and led discussions around the major groups of items on the item set: cognitive, functional, medical, and social/environmental. Background materials included item definitions and rating scales from the assessment instruments currently used in post-acute care settings (MDS, IRF-PAI, and OASIS), as well as a set of discussion questions to focus group discussion on key concepts. Feedback from the TEP led to further revisions to improve item definitions, clarify instructions, and minimize provider burden.

In general, both TEPs agreed on the types of items that were important for measuring differences in patient need and outcomes. Much discussion focused on the language or coding options associated with different items, but most agreed on the basic set of items needed to measure patient populations across settings. All recognized the importance of having standard items that could collect differences in severity without encountering floor and ceiling effects. If possible, additional items would have been included to provide better measurement of specific populations. However, it was recognized that this uniform assessment effort needed a starting point and could be modified in the future. The TEPs thought the modular approach of developing a standard item library that could be added to in the future was a useful model for minimizing burden, providing a range of standard measurement items, and improving the measures available for the future. The approach of building a dynamic instrument that could change with scientific advances was applauded.

ES.5 CARE Item Set Pilot Testing

Two pilot tests were conducted during the early development of the CARE item set. The alpha test, Pilot 1, examined the feasibility of data collection by the two types of providers that do not currently collect patient assessment data: acute hospitals and LTCHs. The purpose of the beta test, Pilot 2, was to examine the feasibility of implementing the CARE item set in four post-acute care settings and acute care hospitals. CARE item set measurement attributes and item response rates from the pilot test were examined.

All items in the CARE item set demonstrated their ability to garner responses in all settings. In four of the seven domains, most settings had item response rates of at least 80 percent. Items addressed to all patients in the survey had the highest response rates. Items calling for open lists, such as diagnosis, medications, and procedures, were thoroughly filled out, in some cases using all available space.

Rates of response to skip-logic questions in the pilot test were lower than for items without screening questions or special instructions. Contradictions were found in respondents' answers to screening and subsequent items. Most items that were to have been answered only by screened respondents were answered by both screened and unscreened respondents. Attention to the flow of items, formatting, and instructions may be necessary to improve response rates for the desired respondents and eliminate responses by those to whom questions do not pertain. These issues were addressed in the refined training materials.

Analyses of responses to the function items also were conducted. We concluded that the CARE rating scale steps are working effectively to describe different levels of patient function. Even though some facilities had difficulty selecting the appropriate level of supplemental items

for patients, resulting in less than full identification of their functional status, the functional scales demonstrate construct validity and the constructs are stable across patients.

ES.6 Office of Management and Budget Paperwork Reduction Act Review Comments

Following pilot testing, the CARE item set was submitted for review to the Office of Management and Budget (OMB) as part of the review process mandated by the Paperwork Reduction Act (OMB-PRA) on July 17, 2007, and was twice published in the *Federal Register* (July and November, 2007). Each publication included a burden estimate based on the pilot test experience. These estimates ranged from a 30-minute assessment completion time for the healthier patient to 60 minutes in the LTCH or SNF, where patients may be more complicated medically and/or functionally or have greater cognitive impairments. These average times of completion reflect experience with the item set, following training on the appropriate measurement methods, and are consistent with current intake assessment times. Most of these items are already collected on the respective intake assessments, so these items in particular would not add much, if any, time to actual assessments if only one assessment were used.

RTI and CMS staff held several meetings to review, categorize, and discuss responses throughout and subsequent to the 60-day public comment period ending September 25, 2007. A total of 79 comments were received from individuals, physicians, nurses, occupational therapists, physical therapists, speech-language pathologists, social workers, case managers, hospitals, LTCHs, critical access hospitals, SNFs, HHAs, IRFs, professional associations, health care organizations and associations, and family and caregiver associations. Prominent industry associations such as the American Hospital Association (AHA), American Medical Rehabilitation Providers Association (AMRPA), American Congress of Rehabilitation Medicine (ACRM), Association for the Advancement of Wound Care (AAWC), American Association of Retired Persons (AARP), National Association of Long Term Care Hospitals (NALTH), American College of Certified Wound Specialists, and Visiting Nurse Services of New York sent responses.

Overall, many positive comments were received from health care providers and professional associations supporting the need for development of a consistent, standardized patient assessment instrument to collect data on patient characteristics, treatment needs, and outcomes. Many also applauded CMS' efforts to develop an item set aimed at improving beneficiaries' transitions between care settings, enhancing patient safety, and improving communication across the continuum of care. Participants were pleased with the relatively short length of this item set compared with the MDS or OASIS. Therapists in the SNFs and HHAs generally appreciated the CARE versions of the function items because they perceived them to better document patient impairment and improvement than the items in the current tools. Those working with pressure ulcers and wounds were pleased to have standard approaches suggested by the national wound organizations.

Commenters requested clarification of terms and underscored the need to provide sufficient staff training. There were general concerns regarding provider burden and whether the CARE instrument adequately captures factors important to explaining placement decisions, including physician decision-making processes. Some commenters related concerns that the CARE item set may affect beneficiaries' access to services and/or may be used to determine

post-discharge placement of patients in particular level-of-care settings. Commenters also raised the issue that the CARE item set has a "one size fits all" approach that will lead to unrealistic expectations regarding its usefulness for clinical purposes, reimbursement, and outcomes analysis. RTI and CMS responses to these areas of concern addressed the plan for staff training and the development of the user's manual. RTI and CMS further explained that the purpose of the item set was to capture standardized data related to severity of illness and degree of impairment and that the data are expected to be predictive of resource utilization and outcomes, not to dictate treatment nor direct discharge placement. Finally, the CARE item set was designed with both core and supplemental items, allowing for skip patterns with certain supplemental items addressing important subpopulations, such as those with pressure ulcers. The technology for automating the CARE item set, in modules, will facilitate revisions to the CARE item set.

CMS also received comments suggesting general changes and other comments recommending revisions, deletions, and additions to specific assessment items. Quite a few suggestions were for specific wording changes or requested clarification. Suggestions for item refinements, additions, and exclusions were reviewed by the four RTI clinical workgroups, and a revised item set was published in the October 31 *Federal Register* and used in the final PAC-PRD data collection.

ES.7 The CARE Item Set: Potential Challenges and Future Enhancement

The collection of systematic assessment data requires thoughtful implementation. As with current assessment processes, the individuals involved in the collection and encoding of data need to be trained to collect accurate data and provided with resources should questions about coding occur. Within the CARE item set, some items will be easy to complete, while others will be more difficult. In addition, familiarity with coding items will vary by setting. For example, functional status data are collected in all post-acute care programs, but acute care nurses do not typically document patients' functional status. As appropriate, acute care nurses will need to work with therapists to ensure data are accurate. Using the web-based item set will minimize some of these challenges, as will increased training for clinicians and strong on-site champions of the item set.

The development of the CARE item set with a web-based platform also provides opportunities for future enhancements by building on the current item set. The development of the CARE item set described in this report represents the initial effort to develop a core set of items that measure the characteristics and needs of typical patients. One possible enhancement is the addition of items that further characterize a patient's medical condition in terms of severity and health care services needed. Patients with stroke and patients with spinal cord injury represent two groups for whom more complete assessments can be given using diagnosis-specific data that are routinely collected by health care providers.

ES.8 Conclusions

In developing the CARE item set, CMS achieved a number of goals envisioned at the outset of the PAC-PRD. CMS achieved its goal of developing a standardized assessment instrument that is useful; clinically relevant; grounded in scientific evidence; flexible for easy, rapid accommodation of future clinical and technological advances; electronically based on

federally and nationally recognized standards for interoperability across settings; and generally supported and accepted by stakeholders.

CARE lays the groundwork for enabling providers to use a uniform set of data elements to assess beneficiaries' progress and outcomes achieved in relation to resources used in various health care provider settings. The item set successfully meets the legislative directive to collect data predictive of outcomes and resource utilization that can guide quality and payment policy development. Additionally, CARE provides a standardized data collection vehicle for measuring beneficiaries' health and functional status longitudinally across settings and episodes of care. This will enhance clinical communication by standardizing the language used to measure patient severity and allow electronic exchanges that can facilitate better care coordination.

CARE successfully moves CMS and providers forward from the use of multiple incompatible assessment instruments to one standardized set of clinically relevant data that applies federally and nationally recognized health information technology standards. Use of broadly adopted health information technology standards will allow for safe, secure, electronic exchange of critical health information among authorized users.

SECTION 1
INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) has undertaken a major initiative to evaluate and realign the incentives for inpatient and post-acute services provided under the Medicare program. Currently, about a fourth of all beneficiaries are admitted to a general acute hospital each year; almost 35 percent of them are discharged to additional care in a long-term care hospital (LTCH), inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), or home with additional services provided by a home health agency (HHA) (Gage et al., 2008). While these services constitute a continuum of care for the patient, the current measurement systems do not allow Medicare to examine the effects of these continuing services on the patient's overall health and functional status.

The Medicare program currently mandates that IRFs, SNFs, and HHAs each submit assessment data on the beneficiary's medical, functional, and cognitive status. This information is used in both the payment and quality monitoring efforts at CMS. Medical status is also measured to some extent in the MS-DRG based case-mix system used to pay and monitor admissions in the acute hospital settings, both the short-term and long-term care hospitals. Despite the inclusion of these factors in the existing systems, each system was developed independently and uses different items to measure each set of concepts. For example, only the PAC settings (IRF, SNF, and HHA) measure functional status and cognitive status independent of diagnosis codes. And each of the three PAC measurement systems (IRF-PAI, MDS, and OASIS, respectively) use different items to measure function and cognition. As a result, the Medicare program has not been able to measure changes in a patient's health status as they progress across their episode of care. Further, this lack of standardized measurement makes it difficult to understand the extent to which patients differ clinically in their use of different PAC settings. Past research has suggested that, after controlling for differences in patient complexity, site of care decisions may be associated with the availability of different service options (Gage, Morley, Constantine, et al., 2008). These analyses are based on the standardized case-mix data available in claims. However, this limited information may mask actual differences in patients using each PAC provider and their outcomes associated with service use. Without standardized ways to measure the patients' medical, functional, and cognitive status, CMS is unable to adequately examine whether the costs and utilization patterns reflect differences in patient case-mix complexity or other factors not related to individual patient needs. Given the differences in program costs associated with each type of Medicare provider and the potential impact on outcomes associated with different treatment approaches in the different types of providers, it is important to understand the extent to which differences in program costs and service utilization reflect patient needs, local practice patterns, or local supply options.

The Deficit Reduction Act of 2005 directed CMS to address this issue and develop methods for measuring Medicare beneficiaries' health status in a consistent way that would allow CMS to examine whether Medicare's various payment systems introduced inconsistent incentives for treating clinically-similar patients. This contract addresses this issue by developing and testing the use of a standardized set of items for measuring medical, functional, cognitive, and social support factors in the acute hospital, LTCH, IRF, SNF, and HHA. These items are based on the science behind currently mandated assessment items in the Medicare

payment systems, including those in the mandated IRF-PAI, MDS, and OASIS instruments. Over the past few years, RTI has been working with the Office of Clinical Standards and Quality, as well as the five different research and clinical communities associated with acute and PAC services, including case-mix measurement experts, accreditation bodies, such as JCAHO, CARF, provider associations, and others to identify a select set of items that would be appropriate for measuring beneficiary severity of illness, regardless of site of care.

Input was collected through various stakeholder meetings, including several Open Door Forums (ODFs) and Technical Expert Panels (TEPs). Two types of TEPs were conducted. The first set of clinical experts were invited to identify the types of items that were important for measuring case-mix differences that may explain patient complexity and the need for different types of services. The second set of discussions focused on measurement issues. They included experts from the acute hospital, LTCH, IRF, SNF, and HHA research communities. The results of these panels were submitted for publication in the *Federal Register* and underwent two sets of public comment periods. The results led to the development and pilot testing of the Continuity Assessment Record and Evaluation (CARE) tool. The items were revised following the pilot test and the resulting changes were implemented for use in the Post-Acute Care Payment Reform Demonstration (PAC-PRD).

The report is organized in three volumes. The first volume in this series details the development of the CARE item set. The second and third include results from testing of the CARE item set during the demonstration.

- Volume 1 is a report on the development of the CARE item set. Section 1 provides an overview of the project, and Section 2 details the purpose and methods of the CARE item set development.
- Volume 1, Section 3, describes in detail the justification for including each of the CARE items in the assessment, including support from the literature.
- Volume 1, Section 4, presents the process of obtaining stakeholder input for the development of the CARE item set through Technical Expert Panel meetings.
- Volume 1, Section 5, gives an overview of the two pilot tests of the CARE item set that were conducted as part of the CARE item set development.
- Volume 1, Section 6, presents the process and CARE item set changes resulting from the Office of Management and Budget clearance review process.
- Volume 1, Section 7, describes potential opportunities and challenges for the CARE item set identified at the end of the initial item set development.
- Volume 2 is a report on the reliability testing of the CARE item set. Section 8 provides an overview of the issues and our approach for testing the reliability and validity of the standardized items developed to create consistent measurement approaches across inpatient and PAC services.
- Volume 2, Section 9, presents the methodology and results of the traditional inter-rater reliability tests on paired assessments in each of the five settings (acute, LTCH, IRF, SNF, and HHA).

- Volume 2, Section 10, reports the results of the cross-disciplinary, cross-setting analysis of reliability using videos.
- Volume 2, Section 11, contains additional analyses of internal consistency, focusing specifically on development of the functional status subscales in the standardized items.
- Volume 3 is a comparison of the CARE item set and current assessment items. Section 12 introduces the analyses conducted to examine the comparability of the CARE item set to items on assessment tools (IRF-PAI, MDS 2.0, and OASIS-B) being used by Medicare certified providers at the time of data PAC-PRD collection.
- Volume 3, Section 13, examines the comparability of the standardized CARE items to those currently in the IRF-PAI assessment tool. This section presents differences in the actual items and crosswalks the two sets of items conceptually to help the reader understand the differences and overlap in the standardized items relative to the current IRF-PAI items.
- Volume 3, Section 14, examines the concurrent validity of the CARE items relative to the MDS 2.0 items for each patient in the SNF sample. While the MDS 3.0 went into effect in 2010, the results are compared to the assessment data used at the time of data collection. Due to the close collaboration of the CARE development team with the MDS 3.0 development team, many of the CARE items are intentionally similar to those in the MDS 3.0.
- Volume 3, Section 15, reviews the CARE items relative to the OASIS-B items. While OASIS-C has since gone into effect, OASIS-B was being used during the time of the reliability tests. The CARE items were based on discussions with the OASIS-C developers to create consistency in item modifications.
- Although many of the CARE items are consistent with those being put forth in the MDS 3.0 and OASIS-C, the comparison analyses had to use data from the existing mandated assessments at the time of each test for each of the patients in the respective CARE samples. Hence, comparisons are made with MDS 2.0 and OASIS-B. In their entirety, these analyses will be used to further refine the current CARE item set, as outlined in Volume 3, Section 16, which considers conclusions and next steps.

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SECTION 2
STUDY PURPOSE AND METHODS

2.1 Overview of the Project

This project was charged with developing a standardized patient assessment tool for use in the Post-Acute Care (PAC) Payment Reform Demonstration mandated by Congress under the Deficit Reduction Act of 2005. The tool will standardize patient assessment information for Medicare beneficiaries discharged from an acute hospital, or admitted or discharged from a post-acute setting, including a long-term care hospital (LTCH), inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), or home health agency (HHA). It incorporates CMS' related efforts to update existing assessment tools, such as the MDS 3.0 and OASIS-C, as well as builds on the lessons learned in the IRF-PAI Quality Indicators study. This tool, the Continuity Assessment Record and Evaluation (CARE), builds on these efforts and creates a standardized subset of items important for measuring patient cost, quality, or outcomes in the Medicare populations. The CARE tool will be used in the demonstration to measure individual medical severity, functional and cognitive impairment, and to identify social support factors affecting the beneficiary's treatment needs and outcomes. It builds on the science behind the 2006 Recommendations for a Uniform Patient Assessment for Post Acute Care (Kramer and Holthaus, 2006) and the three mandated Medicare assessment tools, as well as assessment tools commonly used by general and long-term acute hospitals.

This work is important because one-third of all Medicare hospital patients are discharged to post-acute care settings (Gage, Morley, and Green, 2007). Yet, little information is available to compare the effectiveness or relative outcomes of patients treated in these settings. Each setting uses a different assessment tool to measure patient severity and functional impairment levels. Acute hospitals, both general and LTCHs, each use their own assessment tools when a patient is admitted. IRFs, SNFs, and HHAs each use their respective federally mandated tools, including the IRF Patient Assessment Instrument (IRF-PAI), the SNF Minimum Data Set (MDS), and the HH Outcome and Assessment Information Set (OASIS). While these tools measure similar concepts, the specific items often differ across systems, making it difficult to compare the acuity of populations treated in each setting or differences in the outcomes associated with each treatment. The inability to compare across PAC settings is not inconsequential—Medicare payments may vary substantially for similar patients in different PAC settings with little evidence that this payment difference translates into significant benefits for beneficiaries. In addition, little empirical evidence is available regarding outcomes differences across PAC settings; as a result, differences in quality of care for Medicare beneficiaries may go unrecognized.

This work addresses these issues by developing a standardized tool to measure patient conditions and impairment levels across settings. Similar efforts have been undertaken in the past but have failed because of a lack of consensus on the best measures to use in each setting or because of perceived burden for certain settings. This work addresses these issues by building on the current scientific evidence in each area, using a flexible tool that can change as medicine changes, and incorporating stakeholder input throughout the process. The CARE tool is a dynamic framework for a standard set of measures which can be made available through an item

library. This will ensure standard items are used while allowing providers to vary in the domains they measure. The CARE tool contains two types of items: a core to ask of any beneficiary receiving treatment and a supplemental set of additional standardized items specific to various types of conditions. These supplemental items provide more granular measurement of severity for those who have a condition. By standardizing the language that clinicians use across sites of care, advances can be gained in measuring acuity, outcomes, and treatment needs, as well as improving information transfers between settings.

2.1.1 Building on the Current Scientific Knowledge

Recommendations for items to include in the CARE tool were based on a critical review of the current assessment tools and incorporation of proposed changes in the MDS 3.0, the OASIS-C, and the IRF-PAI QI, as well as consideration of the World Health Organization's development of the International Classification of Function (ICF) model and other measurement efforts in the fields of critically complex medicine, wound care nursing, and related areas. To be considered, items had to have been validated with at least one population and be free of copyright restrictions.

RTI brought together a wide range of clinicians, providers, and researchers to review existing measures in each field and to develop a consensus regarding the best measures of each concept. Items were selected or developed based on their importance for measuring patient severity, resource needs, or outcomes and their ability to detect differences across the range of PAC patients. Input on the selection of the core items appropriate for measuring baseline complexity, and on the best measures of those concepts was provided by teams of clinicians representing each of the five levels of care, including acute hospitals, LTCHs, IRFs, SNFs, and HHAs.

Clinical input occurred at several stages, including initial development by our team of medical consultants from the University of Pennsylvania, Case Western University, RAND/Veterans Administration, and the Visiting Nurse Services of New York. Their work was taken to two different Technical Expert Panels (one representing clinicians and providers from each level of care and one representing measurement experts from each level of care) and integrated with input from providers participating in the two pilot tests.

Data collected in the pilot tests were tested for validity and reliability in each setting. While the sample sizes were small in the pilot tests, they provide important information regarding the feasibility of using each item in the different treatment settings.

2.1.2 Use of a Flexible Electronic Instrument

The CARE item set is designed as a starting point for standardized assessment items across the Medicare program. Additional items or modules can be added in the future but this work focused on the minimal items needed to measure baseline acuity or quality of care. The CARE item set contains two types of items:

a. A core set to describe the acuity of any patient, including their medical, functional, and cognitive condition regardless of severity or type of condition

b. Supplemental items that only apply to patients having a certain trigger condition or characteristic. For example, all patients will be screened for skin ulcers (core item) but only those who have a pressure ulcer at stage 2 or greater will answer the supplemental items on skin integrity (supplemental).

Supplemental items have been developed for medical conditions, functional impairments, cognitive impairments, and home discharges. By using a core and supplemental approach, the CARE item set can limit data collection burden to basic information on the healthier population but also provide standard items to measure severity and outcomes for the less healthy populations.

The electronic component is being designed as a dynamic tool to provide a standard item library for measuring different concepts. This first generation tool targets basic core and supplemental items for measuring frequently occurring conditions in the Medicare populations, such as medical, surgical, and functional conditions. Its relational structure will allow items or modules of standard items to be added in the future. For example, CARE lacks the care planning items common to both the MDS and OASIS tools; yet it has been designed in such a way that these items can be merged by beneficiary identification information to the standardized medical, functional, cognitive, and social support items in CARE, if desired. Effectively, CARE contains a limited set of standard payment and quality measures that can be merged with items from other tools to address care planning or other initiatives. It has been designed to meet federal IT requirements for standard, interoperable language applications.

2.1.3 Gaining Stakeholder Input Throughout the Process

Stakeholders played a key role throughout the process. Provider associations from each of the five levels of care nominated TEP participants, organized small group meetings for their members to meet with RTI and CMS, reviewed materials, and provided feedback on the tool. Providers from each level of care participated in the pilot tests and resulting tool refinement discussions. Input was collected on the relative ease of completing each item with their populations. Provider input was also given on the practical considerations, including the training sessions, and the web-based data entry and submission system. Stakeholders provided feedback to the IT developers on everything from screen content to better methods for moving between sections of the tool.

This first year report summarizes the work that was conducted and the methods used at each stage in developing the CARE tool. Section 1 identifies the project goals and presents a roadmap for the report; Section 2 provides an overview of the tool, the clinical workgroups' review of existing instruments and their applicability to measuring severity, resources, or outcomes, and the justification for including each proposed item. Section 3 summarizes the discussion at the Technical Expert Panel meetings and highlights comments within each domain. Section 4 discusses the results of the two pilot tests that were conducted to examine the usefulness of each item in the different settings. The pilot test data were examined to assess the validity and reliability of these items in each setting, with particular focus on the extent to which items were consistently used in each setting. Section 5 describes the public comments received during the two *Federal Register* publications (July and October) and summarizes the final set of changes made prior to the demonstration phase. Section 6 discusses the next steps, including the

limitations of the tool at this point in time. Of particular interest is the need to further develop item modules for other populations, such as the psychiatric or long-term care populations. Further work is needed on the supplemental items to add outcome measures for some of the less frequent types of Medicare populations, including those with spinal cord injuries or traumatic brain injuries where additional information may be needed to distinguish severity within diagnostic groups. Last, additional work is needed on ensuring inter-organizational reliability. A large scale testing of these items will need to be conducted before payment models can be built on them. Their robustness in consistently measuring the same factor will need to be further documented on a larger sample.

2.2 Study Methods

The Deficit Reduction Act of 2005 mandated that the PAC PRD be in place by January 2008. This timeline required that the CARE tool be ready within a 14-month window. Given that the charge was to build on the current science, develop a consensus regarding the most appropriate measures from each field, and test the tool in each of the five settings, this work progressed on a steady schedule. This section briefly describes the activities conducted throughout the year.

2.2.1 Defining the Domains

The first step in developing this instrument was to examine the domains common to each existing assessment tool and determine which types of concepts should be included in this tool. The tool needed to effectively measure patient severity factors that would predict the need for different types of treatments or resources or measure outcomes. Based on the 2006 report, *Uniform Patient Assessment for Post Acute Care* (Kramer and Holthaus, 2006), five primary domains were selected. The first four domains are common to most medical assessment tools regardless of site of care (medical, functional, cognitive, and social support). The fifth domain (transition items) was identified as important for improving quality of care. By improving information transfer between sites, avoidable hospitalizations and other conditions can be prevented. Specific information needs may vary by level of care and much work is underway in the medical and long-term care communities to develop these records (Coleman, Mahoney, and Perry, 2005; Ouslander, Perloe, Givens, et al., 2009; the Center for Aging Services Technologies (CAST)). In the future, the results of these efforts can be incorporated as a supplemental module on transitions information. The CARE team restricted transition items to the core set that were critical at time of transfer, such as identifying the diagnoses being treated, the discharge medications, and any known patient allergies. Providers from all PAC levels of care identified these items as common to all transfers.

2.2.2 Forming Clinical Workgroups

The initial RTI work was done by a large team of clinical staff from various backgrounds, including medical and rehabilitation nursing, occupational therapy, physical therapy, physiatry, epidemiology, geriatric medicine, intensive care, and public policy. Members included staff from RTI as well as subcontractors from the Rehabilitation Institute of Chicago, Evanston Northwestern Hospital/NIH PROMIS team, Northwestern University, and consultants from the University of Pennsylvania, Case Western University, RAND/VA, and the Visiting Nurse Service of New York. Extensive input was also provided by our pilot test sites, including RML

Specialty Hospital, Edwards Hospital, Rush Copley Hospital, MarianJoy Rehabilitation Hospital, ManorCare Corporation, and the VNA of Fox Valley. Clinicians represented each of the five levels of care, including acute, LTCH, IRF, SNF, and HHA.

Four clinical workgroups were established to focus on each of the conceptual domains. The medical workgroup debated the core items needed to measure patient acuity and predict resource needs in medical populations, as well as identified supplemental items important for measuring change in these patient population outcomes. This group also reviewed the continuity items given the medical nature of avoidable conditions. Items included in current case-mix or quality reporting systems provided a starting point. The functional workgroup focused on measures of functional impairment, functional ability, and instrumental activities of daily living. Again, items already found to be predictive of resource use or outcomes were considered for their application to other populations with greater or lesser severity. The cognitive workgroup examined items appropriate for measuring acute and chronic impairments that may indicate delirium or other cognitive issues that will effect patient education and resulting outcomes. The social support group focused on issues related to structural barriers, living situations, caregiver availability, and the need for assistance, as well as issues related to discharge complications. Where the RTI team lacked appropriate staff, staff from the pilot sites participated in discussions about item selection and the goal of each recommended item in preparing materials for TEP review. Response burden was a constant criteria applied in each workgroup. The final list of items proposed to the TEPs was restricted to those measuring patient treatment needs or outcomes. Each item needed to be justified for its inclusion in the CARE tool (see Sections 2 and 3 of this report).

2.2.3 Pilot Tests

Two sets of pilot tests were conducted in the Chicago area (see Section 4). The first pilot test included only acute hospitals and long-term care hospitals to test item appropriateness in these populations and to develop procedures that would complement current assessment and workflow practices. The second pilot test included all five types of providers and examined how well the tool worked in each setting and across a range of patients. The pilot tests ranged from 3 weeks to 6 weeks; settings with longer stay patients needed longer test periods to allow completion of both an admission and discharge assessment. The results of the pilot test were used to modify the CARE tool prior to publication in the July *Federal Register*.

2.2.4 Public Comment

Public comment was incorporated in several stages. First, two Open Door Forums were held in December and March to provide information on the demonstration and to invite input on the instrument's development. RTI established a specially designed website address to allow providers, clinicians, and other individuals to submit comments on the content of the tool and to bring to the team's attention to issues that may be specific to one of their populations or settings which should be considered in designing this tool. These comments were incorporated in the clinical workgroups' efforts. Each of the national associations also published the address for submitting comments and invited members to do so. Many invited the project team to present information about the tool and the forthcoming demonstration at their national meetings and each of these presentations invited attendees to submit comments to the available website. Additional

small group meetings were held by phone to discuss ideas regarding content or operational use of the tool in each level of care.

The CARE tool was published twice in the *Federal Register*. Each publication included a burden estimate based on the pilot test experience. These estimates ranged from 30 minute assessment completion time for the healthier patient to 60 minutes in the long-term care hospital or skilled nursing facility where patients may be more complicated medically, functionally, or have greater cognitive complications. These average times of completion reflect experience with the tool, following training on the appropriate measurement methods.

Comments were received from a wide range of the public, including clinicians, administrators and others. Several issues were raised repeatedly by different types of respondents:

- **There was wide consensus and support for developing a standard assessment tool for use in the Medicare program.** Almost all respondents pointed to the importance of this effort for improving quality of care by standardizing the language used to measure illness and impairment; and the value of having the federal government sponsor this work.
- **Respondent burden.** Reviewers were concerned with the length of time that standardized assessments would take to complete. While the pilot test participants were pleased with the relatively short length of this tool compared to the MDS or OASIS, commenters feared the CARE tool would be an additional reporting requirement rather than a replacement of other, similar assessment mandates. While CMS' goal is to identify or develop the best items for measuring a concept and to replace the current varying items with one standard item across settings, this was not clear in the *Federal Register* materials.
- **Suggestions were offered for item refinements, additions, and exclusions.** These suggestions were reviewed by the four RTI clinical workgroups and a revised tool was published in the October 31 *Federal Register*.

SECTION 3
CARE TOOL ITEM JUSTIFICATIONS AND SUPPORTING LITERATURE

The CARE tool is designed to measure patient resources, outcomes, and quality of care. It builds on the 2006 recommendations for a uniform assessment instrument (Kramer and Holthaus, 2006) and provides a framework for the 31 proposed domains to understand patient resource needs, care transitions, quality and outcomes. These domains can be grouped into four patient assessment areas: admission, social support, medical, and functional (physical and cognitive) areas. An additional section captures administrative information. A subset of items under each of the four patient assessment domains is likely to measure the presence or absence of conditions that will be important predictors of treatment needs, outcomes, or quality of care. The content was developed incrementally based on the science behind the current Medicare payment and quality measurement systems, assessing the applicability of items in one system for use with populations treated in a different level of care, and examining alternative validated items from other commonly used assessment tools, such as the COCOA-B in the PACE projects, or the VA system. Results from CMS' ongoing DAVE, STRIVE, and OASIS update efforts were also incorporated.

The final set of measures needs to meet several conditions. First, it must be limited in number to minimize provider burden. Second, items need to be useful across severity groups and capture the range of severity without being restricted by floor or ceiling effects. Third, the assessment method may vary by whether an item should be self-reported, interview-based, or performance-based as payment and outcomes monitoring may be based on these measures. Fourth, the assessment periods or windows need to be standardized across settings. Consistent assessment windows (e.g., "x days before or following hospital discharge") are required to allow comparison of patient acuity at the same point in time, regardless of subsequent service sites. Last, the frequency of patient assessment needs to be determined.

Given the use of the CARE tool as a payment and quality monitoring tool, and CMS' concerns with provider burden, the workgroup proposed limiting patient severity measures to the time of discharge, and in the PAC settings, to both discharge and admission so both baseline and changes in severity of illness can be measured. Significant changes in condition may also trigger an additional assessment in the PAC setting. Actual assessment periods are similar to those currently used in each setting with some information collected at the time of admission, such as information on the patient's preadmission health status and social support system, while other items are time-sensitive item and must be collected in the 2 days prior to discharge or first 2 days of admission. Time-sensitive items are those that measure major treatment needs at discharge (or admission), functional impairment levels, cognition and pain. Many of the items can be collected from the medical record, such as the clinicians' assessment of the primary and complicating conditions being treated, medications at discharge, and patient allergies. These items are important for safe transitions but are not used in the payment or quality monitoring systems.

Given these goals, the workgroup recommended that the CARE assessment tool should measure patient severity at time of discharge from the hospital (to provide a standard measure of patient severity for examining quality of care and access issues) and at admission and discharge from PAC settings (to measure the severity of patients admitted to different types of settings and

the outcomes associated with that care). The results of the clinical workgroups were presented to the Technical Expert Panels (TEP) for further discussion.

Items were chosen based on their ability to detect differences across the range of acute and post-acute levels of care. The CARE tool development team relied heavily on literature and research that has examined the validity of existing items and rating scales, including those used in current Medicare payment and quality monitoring systems. Some items are only relevant at admission; others are important at discharge, especially if a patient is returning to the community. ***Appendix A*** is the working document used to compare similar items across tools existing at the time of the CARE tool development, including the OASIS, IRF-PAI, MDS 3.0, and COCOA-B instruments. The last column identifies the item proposed for the CARE tool and the reason for inclusion.

This section presents an overview of the CARE tool items, the reason each was proposed, and identifies whether an analogous item was used in a Medicare PPS or quality monitoring system at the time of the CARE tool development. This section focuses on the complete set of items tested in the two pilot tests and submitted to the Office of Management and Budget (OMB) for clearance in July 2007. However, the actual tools vary in terms of which items are included. Points raised by the TEP are in Section 3 and subsequent modifications since the OMB submission are discussed in Section 5 of this report (see ***Appendix B*** for a copy of the CARE assessment subsequent to the OMB submission). ***Appendix C*** identifies which version of the CARE tool an item is on and whether it is a core or supplemental item. The final tool to be tested in the demonstration is presented in ***Appendix F***.

3.1 Administrative Items

The administrative section of the CARE tool consists of core items that identify the type of assessment and provide basic patient, provider, and payer information. Many of these are standard items on Medicare reporting forms and much of this information is collected during patient admission activities. These items include Medicare provider number, patient name, date of birth, Medicare health insurance identification number, and social security number (optional). The payer information identifies all current sources of payment for the service. Demographic information on gender, race/ethnicity, and language and translation service needs are also included. Advance care directives were also originally included in this section although later discussions moved this information to a separate overall plan of care section (Section IX).

Each of the administrative items is important for assuring quality and continuity of care during patient transitions. ***Table 3-1*** provides additional detail on the potential use of each of the administrative items. Birth date or age is reflective of frailty and potential increased resource utilization. Age may also be predictive of type of post-acute care provider used since more elderly patients are likely to be discharged to SNFs (Liu, Gage, Harvell, et al., 1999; Ross, Dummit, Gage, et al., 1999).

Table 3-1
Administrative items: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS	IRF PPS	HHA PPS
A. Assessment Type							
A1. Reason for Assessment	—	—	—	—	Yes	—	Yes
B. Provider Information							
B1. Provider's Name	—	—	—	Yes	—	—	—
B2. Medicare Provider's Identification Number	—	—	—	Yes	—	—	—
B3. National Provider Identification Code (NPI)	—	—	—	Yes	—	—	—
C. Patient Information							
C1. Patient's First Name	—	—	—	Yes	—	—	—
C2. Patient's Middle Name	—	—	—	Yes	—	—	—
C3. Patient's Last Name	—	—	—	Yes	—	—	—
C4. Patient's Nickname	—	—	—	Yes	—	—	—
C5. Patient's Medicare Health Insurance Number	—	—	—	Yes	—	—	—
C6. Patient's Medicaid Number	—	—	—	Yes	—	—	—
C7. Patient's Identification Number	—	—	—	Yes	—	—	—
C8. Birth Date	—	—	—	Yes	—	Yes	—
C9. Social Security Number	—	—	—	Yes	—	—	—
C10. Gender	—	—	—	Yes	—	—	—
C11. Race/Ethnicity	—	—	—	Yes	—	—	—
C12. Is English their Primary Language	—	—	—	Yes	—	—	—
C12a. If not, is an interpreter available?	—	—	—	Yes	—	—	—
C12b. If not, what is the patient's primary language?	—	—	—	Yes	—	—	—
C13a. Patient's choices documented in medical record	—	—	—	Yes	—	—	—
C13b. Medical record documents authority to make decisions	—	—	—	Yes	—	—	—
C13c. Medical record documents whether to resuscitate	—	—	—	Yes	—	—	—
D. Payer Information							
D1-D13. Current Payment Sources	—	Yes	—	Yes	—	—	—

SOURCE: RTI International.

3.2 Admission Information

The admission information section documents preadmission information, including where a patient was admitted from, whether they used other medical services in the past 2 months, and if so, what was the primary condition being treated in the last setting. Most of these items are core items, although those referring to prior service use are supplemental and apply only to patients who received those services. The items in this section are collected for continuity of care purposes as well as to highlight patient severity and to provide risk-adjustment measures for examining outcomes. Past service use provides important information about a patient's severity and potential resource utilization needs.

The admission information section also collects information on the patient's living arrangements prior to the start of this episode of care. Specifically, the tool asks whether the patient lived independently in the community, if so, with whom did they live, and were there any structural barriers in their residence that may affect discharge decisions. Each of these items can be predictive of post-acute care discharge options and resource utilization. For example, studies of discharge planning have examined the effects of a patient's social network on discharge status and showed that potential informal caregivers are predictive of discharge to the community (Buntin, Garten, Paddock, et al., 2004; Liu, Gage, Harvell, et al., 1999; Murtaugh, 1994).

Functional status measures are a strong predictor of patient outcomes, resource utilization, and mortality (Inouye, Peduzzi, Robison, et al., 1998). Understanding a patient's functional status prior to admission incorporates risk adjustment measures that allow outcome comparisons across patients, particularly in measuring and understanding functional declines or improvement during a treatment period. Prior function measures in the CARE tool include the ability to perform everyday activities such as self-care, mobility (ambulation and wheelchair), stairs, and functional cognition as well as the need for mobility devices and aids.

Additional items which can be predictors of patient outcomes and resource utilization include history of falls and mental status prior to an episode of care. Falls are often associated with decreased mobility and general functional status and may result in severe injuries such as hip fracture, other fracture, hematoma, or head injury. Understanding a patient's risk for falling is important in predicting resource utilization. It has been documented that approximately half of the falls in patients over 65 years of age are in fact recurrent falls (Tinetti, 2003). Therefore, a fairly strong predictor of future falls as well as resulting resource utilization is a history of falls.

Mental status prior to the current illness, exacerbation or injury was included as an item on the CARE tool to better understand patient severity, resource utilization, patient outcomes and for assuring continuity of care. Understanding a patient's mental status prior to admission is particularly important for establishing a baseline for recognizing changes in mental status, which may be a sign of acute illness or may require specific care interventions (Boockvar, Fridman, Marturano, et al., 2005). Mental status prior to admission is particularly important to convey during interfacility transfers. Suboptimal information about mental status may result in missed diagnoses of conditions such as delirium which can be associated with significant adverse outcomes, particularly in an elderly population (Boockvar, Fridman, Marturano, et al., 2005; Inouye, Rushing, Foreman, et al., 1998). This item was later deleted because other, more precise measures of delirium are in the cognitive section of the tool.

Each of the admission information items is important for inclusion on the CARE tool for measuring patient severity, predicting resource utilization, measuring outcomes or assuring continuity of care. Many of these items are important for standardizing outcomes assessment to adjust for differences in risk, or expected outcomes. ***Table 3-2*** summarizes the reasons for which each of the admission items were included in the CARE tool.

3.3 Current Medical Items

The current medical items section of the CARE tool collects information on the reason for admission, including primary and other diagnoses, procedures, treatments, and physiologic factors. Some conditions, such as pressure ulcers and other major wounds are also included on the CARE tool due to their significant contribution to increased resource utilization. This section includes both core items which are typically recorded on all patients in any setting, and supplemental items which only apply to patients having certain conditions. Supplemental items are typically preceded by a question with a skip logic pattern.

3.3.1 Primary Diagnosis and ICD-9-CM Codes

The primary diagnosis is the reason that a patient was admitted for care to a facility. This core item is important for both continuity of care purposes to communicate why the patient is being treated, as well as being a key factor in stratifying patients in medical case-mix systems, such as the PPS DRGs, LTCH PPS DRGs, and the APR-DRGs. The primary diagnosis item allows assessors to provide a text reference for the condition receiving treatment during a stay. In addition to this text item, the CARE tool collects the corresponding International Statistical Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code.

Capturing enough information to translate a diagnosis to an ICD-9-CM code is important for payment purposes. ICD-9-CM codes provide a wealth of information relating to a patient's condition as well as the severity of that condition. Patient severity has been found to be highly correlated with resource utilization (Wynn, Beckett, Hilborne, et al., 2007). Therefore, as a measure of patient severity capturing diagnosis on the care tool is important. ICD-9-CM codes have also been used in different payment systems to develop case-mix measures. Both the inpatient prospective payment system (PPS) for acute hospitals and long-term care hospitals group ICD-9-CM codes into diagnostic related groups (DRG). Each DRG is created such that patients are similar clinically and in terms of resource utilization within each DRG group. Hospitals are then paid according to the patient's DRG classification. The ICD-9-CM codes are also used in the HH-PPS and are captured through the OASIS tool. Given the critical role of ICD-9-CM codes in Medicare payments, the medical group decided that capturing ICD-9-CM code through the CARE tool would be important. The coding system not only provides a comprehensive set of diagnoses to help understand patient severity but also has been well researched and refined since it was published by the World Health Organization (WHO) in 1978.

Despite the importance of ICD-9 CM level specificity, many studies have indicated that ICD-9-CM coding errors can occur during physician patient interactions and at the point where the coder interprets the medical record. The error rates can range from 20 percent to 80 percent (O'Malley, Cook, Price, et al., 2005). Physicians are often unfamiliar with the correct codes. In fact, many of the payment denials in the Medicare program are due to inappropriate coding

Table 3-2
Admission information: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS[1]	IRF PPS	HHA PPS
A. Pre-admission Service Use							
A1. Admission Date	—	—	—	Yes	—	Yes	Yes
A2. Admission From	—	—	—	Yes	—	—	—
A3a. If admitted from other setting, Last Primary Diagnosis	Yes	—	Yes	Yes	—	—	—
A3b. If admitted from other setting, Last ICD-9 CM	—	—	Yes	Yes	—	—	—
A4a-A4i. Other Services in past 2 months	Yes	—	Yes	Yes	—	—	—
B. Patient History Prior To This Current Illness, Exacerbation, or Injury							
B1. Type of Prior Residence	—	—	Yes	—	—	—	—
B2. If in community, Zip Code of Prior Residence	—	—	Yes	—	—	—	—
B3a-B3g. If in community, Lived With:	—	—	Yes	—	—	—	—
B4a-B4f. If in community, Structural Barriers	—	—	Yes	—	—	—	—
B5a-B5e. Prior Functioning	Yes	Yes	Yes	Yes	—	—	—
B6a-B6f. Mobility Devices	Yes	Yes	Yes	Yes	—	—	—
B7. History of Falls	Yes	Yes	Yes	Yes	—	—	—
B8. Prior Mental Status	Yes	Yes	Yes	Yes	—	—	—

[1] The MDS 2.0 collects information on physician visits and physician orders in the past 14 days. These items are used in the SNF PPS.

SOURCE: RTI International.

relative to the text in the medical record (Gage, Pilkauskas, Dalton, et al., 2007). Further, while ICD-9 codes are reported by LTCHs, IRFs, and HHAs, skilled nursing facilities use check-off lists to identify medical conditions. Hence, the CARE tool collects both a textual description of the diagnosis as well as the ICD-9-CM codes since the accuracy of ICD-9-CM coding is often questionable. Later versions of the CARE tool resolved this issue by keeping a text-based description of the patient's condition for use in clinical continuity discussions and establishing a separate section to be completed by the organization's coder for purposes of billing. This latter item will be used for case-mix analysis.

3.3.2 Other Diagnoses, Comorbidities, and Complications

The primary diagnosis for an admission to a health care setting is not sufficient for understanding the severity of illness and medical complexity of a patient. Patients may have multiple comorbid diagnoses or complications that can affect recovery or treatment. In some cases lack of knowledge regarding comorbid conditions can result in severe adverse reactions. In 1999, it was estimated that 82 percent of Medicare beneficiaries aged 65 years and older had one or more chronic condition and that 65 percent had multiple chronic conditions (Wolff, Starfield, and Anderson, 2002). The presence of comorbidities and/or complications can significantly influence outcomes and resource utilization. For example, per capita Medicare expenditures vary widely depending on the presence of chronic conditions. Medicare beneficiaries without any chronic condition had estimated costs of $211 annually in 1999 compared to those with four or more chronic conditions who had expenditures of $13,973 (Wolff, Starfield, and Anderson, 2002). Similar results have been found in other studies (Zhu, 2004).

These diagnostic items include both core and supplemental items. The first place for assessors to record comorbidities is a core item identifying whether the patient has additional diagnoses that are being treated, managed, or monitored in the setting.[2] The instructions for this section remind assessors to include frequently underreported diagnoses such as depressions, schizophrenia, dementia, and protein calorie malnutrition, since these conditions can significantly impact patient severity, resource utilization, and patient outcomes. Psychiatric comorbidities, in particular, have historically been underreported and have been predictive of higher resource utilization and increased length of stay in hospitals. This is particularly true of elderly patients enrolled in Medicare with schizophrenia or other mood disorders (Bressi, Marcus, and Solomon, 2006). Second and later diagnoses are supplemental items and only pertain if relevant.

Finally, the extent of a patient's comorbidities may affect a patient's discharge options since certain comorbidities and complications may require higher levels of monitoring or specialized equipment that may not be available in every setting (Gage, Pilkauskas, Dalton, et al., 2007; Buntin, Garten, Paddock, et al., 2004). A morbidly obese patient receiving a hip replacement, for example, may be limited to settings that have equipment and safety procedures in place to accommodate a morbidly obese individual.

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[2] The paper version allows for 15 diagnoses to be entered but the electronic version begins with five lines and offers up to 300 lines for the assessors to use.

3.3.3 Procedures (Diagnostic and Therapeutic Interventions)

The CARE tool also contains core items documenting what procedures, if any (diagnostic and therapeutic interventions), were conducted during the admission. It is only included in the discharge versions of the tool but is important for understanding resource utilization, patient severity, and post-acute care discharge options. The procedures item asks if a patient had one or more diagnostic or therapeutic procedures during the admission and if so, up to fifteen procedures and their corresponding ICD-9-CM procedure codes are recorded. These, like the primary and secondary diagnoses are basic measures in the LTCH and Inpatient PPS systems.

Procedures are also indicative of a patient's severity of illness, resource utilization, and next site of post-acute care. For example, a patient receiving a bilateral hip replacement during his or her stay will likely require significant postoperative follow-up and post-acute rehabilitative services. Resource utilization for these patients may be further intensified by the presence of comorbid illnesses and the primary indication for surgery (Lin and Kaplan, 2004).

3.3.4 Treatments

The CARE tool includes check-off boxes for 31 treatments identified by the medical workgroup for their ability to predict severity of illness, resource utilization, post-acute care setting, or patient outcomes. Many of these treatments, such as ventilators, dialysis, oxygen therapy, suctioning, and tracheostomies, were found to be important predictors of high cost care and increased resource use in studies investigating long-term care hospital (LTCH) use (Gage, Bartosch, Leung, et al., 2005). Changes in their use may be important measures of outcome differences for more medically complex cases. However, they are less desirable for payment systems as they give providers incentives to increase discretionary service use if payments are associated with them. Past studies, such as those preceding OBRA 1987, demonstrated how the use of discretionary resource measures in payment systems can result in poor quality care. But changes in the need for these resources may illustrate differences in outcomes associated with different service mixes. A description of each of the treatments included on the CARE tool and its justification for inclusion is outlined in ***Table 3-3.***

Identifying treatments administered during an admission and at discharge is important for several reasons. The type of treatment provides information about the patient's severity of illness and potential health outcomes. For example, insulin drips are used for patients' whose blood sugar levels are extremely out of balance rather than for well-controlled diabetes patients. Treatments may also provide information regarding resource utilization. Patients with severe wounds requiring frequent and/or complex dressing changes with positioning and skin separation/traction may need assistance from two persons instead of a single individual and the need for more than one person to attend to a patient's care needs represents a significant increase in resource needs.

Certain treatments may also influence discharge decisions. The resource intensity associated with certain treatments may dictate discharge options as the availability of more intensive nursing care may vary between types of settings. Patients with chest tubes, for example, are infrequently accepted by home health agencies. Similarly, some post-acute care facilities may not be equipped to handle patients with certain treatment needs such as ventilators or bariatric beds.

Table 3-3
Justification for CARE tool treatment items

Treatment	Treatment item reason for inclusion on CARE tool
Insulin Drip	An insulin drip is used for patients with very uncontrollable blood glucose levels indicative of patient severity of illness and medical instability. This treatment may influence the setting of care that a patient is discharged to due to the requirement for intensive monitoring. Insulin drips are not commonly administered in SNFs or IRFs.
Total Parenteral Nutrition (TPN)	With TPN, a patient is fed intravenously using an infusion pump, bypassing the usual process of eating and digestion. The person receives nutritional formulas containing salts, glucose, amino acids, lipids and added vitamins. TPN is often used following surgery, when feeding by mouth or digestive system is not possible, when a patient's digestive system cannot absorb nutrients due to chronic disease, or if a patient's nutritional requirement cannot be met by tube feeding and supplementation (American Society for Parenteral and Enteral Nutrition, 2008). Short-term TPN may be used if a patient's digestive system has shut down (for instance by peritonitis), and they are at a low weight to cause concerns about nutrition during an extended hospital stay. TPN requires considerable monitoring and management in order to prevent infection. Therefore TPN is predictive of use of nursing services and resource utilization. TPN is not administered in all settings so its use may influence post-acute care discharge placement. For example, TPN is uncommon in many SNFs.
Central Line Management	Central lines require specialized nursing care and monitoring to ensure patency and to prevent infection. Treatment with a central line will therefore influence the setting that a patient is discharged to and will predict resource utilization. Patients with central lines are unlikely to be treated in SNFs.
Blood Transfusions	Blood transfusions require increased nursing care due to the need to identify patient blood type, perform cross-matching, and provide ongoing patient monitoring as the patient receives blood and following the transfusion. Blood transfusions are predictive of resource utilization and post-acute care discharge options.
Controlled Parenteral Analgesia (peripheral and epidural)	Controlled parenteral analgesia is resource intensive in terms of staffing needs and the need for specialized equipment. It is important to differentiate between peripheral and epidural controlled parenteral analgesia because each require different resources. Due to the resource intensity involved, this form of treatment may not be available in all health care settings and may influence post-acute care discharge placement.
Left Ventricular Assistive Device (LVAD)	The LVAD can be used in acute or chronic situations; it takes over the work of the heart after surgery or angioplasty, allowing the heart time to recover, or may be implanted in end-stage heart failure patients who are not candidates for heart transplant. The use of an LVAD will influence post-acute care discharge placement and resource utilization. LVADs require frequent monitoring and management that may not be available in all post-acute care settings. An LVAD is also indicative of patient severity of illness.
Continuous Cardiac Monitoring	Continuous cardiac monitoring is typically indicative of patient severity of illness and instability, a patient with an unstable cardiac rhythm can be closely monitored by specialized nurses and meds adjusted as needed. This treatment is predictive of resource utilization and may influence the post-acute care discharge placement. In order to ensure medical necessity, the CARE tool requires that the reason for continuous cardiac monitoring be specified.
Chest Tube(s)	A chest tube is a flexible plastic tube that is inserted through the side of the chest into the pleural space. It is used to remove air (pneumothorax), fluid (pleural effusion, blood), or pus (empyema) on an acute basis. The use of a chest tube requires nursing and/or respiratory care management and ongoing monitoring that may not be available in all post-acute care settings. Treatment with a chest tube may influence both resource utilization and post-acute care discharge options. This treatment is also indicative of patient severity of illness due to the patient's respiratory status and underlying disease.

(continued)

Table 3-3 (continued)
Justification for CARE tool treatment items

Treatment	Treatment item reason for inclusion on CARE tool
Endotracheal (ET) Tube Care and Management	During episodes of acute respiratory failure, patients are generally ventilated through an endotracheal tube. Treatment with ET tubes requires increased resource utilization due to the need for skilled nursing staff to monitor position and cuff pressure and keep the area clean. This type of monitoring may not be available in all settings so the use of this treatment may influence post-acute care discharge placement. This treatment is also indicative of patient severity of illness. In order to ensure medical necessity, the CARE tool also requires that frequency of the suctioning be specified.
Tracheotomy (Trach) Tube with Suctioning	The use of a trach tube is indicative of patient severity of illness, resource utilization, and post-acute care discharge placement. Patients with trach tubes require frequent monitoring and suctioning of secretions which is resource intensive. The resources required to monitor these patients may limit discharge options for post-acute care.
High Oxygen Concentration Delivery System (FiO_2 > 10%)	High oxygen concentration delivery is indicative of patient severity of illness and also requires specialized equipment and highly trained staff. Due to the specialized equipment and staffing, this treatment may not be available in all post-acute care settings.
Ventilator	Ventilators are not available in all post-acute care settings so their use may influence post-acute care discharge options. Resource utilization associated with a ventilator varies depending on whether a patient is being weaned off the ventilator or whether this patient is ventilator dependent. The ventilator dependent patient is likely to be more stable medically. Therefore the CARE tool includes two items for ventilators in order to distinguish between weaning and nonweaning. This distinction also helps to understand patient severity along with resource utilization.
Hemodialysis	Hemodialysis is primarily used to provide an artificial replacement for lost kidney function due to renal failure, acute or chronic, for a number of medical conditions. Hemodialysis is typically conducted in an undedicated facility, either a special room in a hospital or a clinic that specializes in hemodialysis. The treatment is under the direction of a nephrologist and treatment is typically provided three times a week over 3-4 hours. Hemodialysis is resource intensive and requires specialized nurses and technicians, patient vital signs are monitored closely during treatment and there is frequent lab work. Therefore its use may limit post-acute care discharge options. The use of hemodialysis is also indicative of severe kidney disease which is often a sign of medically complex patients with multiple comorbidities.
Peritoneal Dialysis	In peritoneal dialysis, the dialysate solution is run through a catheter into the peritoneal cavity, where the peritoneal membrane acts as a semipermeable membrane. The dialysate is left there for a period of time to absorb waste products, and then it is drained out through the tube and discarded. This cycle is normally repeated 4-5 times during the day, (sometimes more often overnight with an automated system). Peritoneal dialysis also requires more intensive monitoring and nursing care but is widely available in many of the PAC options. This item is a measure of patient severity and an important adjuster for outcomes, but not likely a differentiator of resource use.
Fistula or Other Drain Management	Fistula or other drain management is predictive of resource utilization and post-acute care discharge placement. These treatments require ongoing staff monitoring that may not be available in all post-acute care settings.
Negative Pressure Wound Therapy	Negative pressure wound therapy is indicative of resource utilization, post-acute care discharge options and severity of illness. This treatment may not be available in all post-acute settings and therefore limits discharge placement options (Armstrong and Lavery, 2005).
Complex Dressing Changes	Complex dressing changes that involve positioning and skin separation/traction or require two or more persons represent significant resource utilization. Patients requiring complex dressing changes are also likely to have higher levels of severity of illness.

(continued)

Table 3-3 (continued)
Justification for CARE tool treatment items

Treatment	Treatment item reason for inclusion on CARE tool
Halo	The presence of a halo is indicative of severity of illness, resource utilization, and post-acute care discharge options. The use of a halo requires additional staff to assist the patient and to help reduce the risk for infection. Some settings may not be equipped to handle this additional resource need or have staff skilled in this treatment.
Complex External Fixators	Complex external fixators such as the Ilizarov are often used to treat complex fractures and require specific expertise to manage. This management is resource intensive and may not be available in all post-acute care settings.
One-on-One 24 Hour Supervision	One-on-one 24-hour supervision is resource intensive. While these staff may be less expensive than skilled nursing, their individual assignment makes them expensive. They are not always available in all post-acute care settings. In order to ensure medical necessity, the CARE tool also requires that the reason for the one-on-one supervision be specified.
Specialty Bed	The need for a specialty bed, such as a bariatric bed, is indicative of increased resource utilization. Specialty beds may not be available in all settings and may limit post-acute care discharge options.
Multiple IV Antibiotic Administration	Multiple IV antibiotic administration is indicative of severity of illness, resource utilization, and may influence post-acute care discharge options.
IV Vaso-actors	The use of vaso-actors requires close monitoring and medication adjustment. This treatment is not available in all post-acute settings and is resource intensive.
IV Anti-coagulants	The use of IV anti-coagulants requires monitoring and medication adjustment, thereby requiring more intensive resources. This treatment is not available in all post-acute settings.
IV Chemotherapy	This treatment may not be available in all settings due to intensive resource use and monitoring. The resource use and monitoring required depends on the particular chemotherapy regime. This treatment also indicates severity of illness.
Indwelling Urinary Catheter, Intermittent Urinary Catheterization, Ostomy, External Fecal Management System	These treatments reflect three scenarios: 1) the patient had one or more than one of these devices prior to admission which are self-managed and in this case these items are related to continuity of care across post-acute settings; 2) the patient had one or more of these devices prior to admission but due to the patient's medical or cognitive condition, the patient now requires assistance, monitoring, and/or education; and 3) the device is new to the patient and they may require assistance, monitoring, or education. Any of these devices may reflect more intensive resource utilization and specialized staff. However, these items are also captured later in the tool and were removed from this section to reduce provider burden.

SOURCE: RTI International.

3.3.5 Medications

The discharge version of the CARE tool includes a section for the assessor to record all current medications for the patient at time of discharge. The medications section includes space to record the medication name, dose, route, frequency, and planned stop date. Recording each of a patient's medications provides additional information on patient diagnoses (both primary and comorbidities) and severity of illness. The use of certain medications may also limit post-acute care placement options. For example, patients on complex intravenous drugs requiring significant monitoring and medication adjustment may not be accepted by all settings. Also, the costs associated with certain prescription drugs are indicative of resource utilization.

Another very important reason for recording medications on the CARE tool is to improve care transitions across settings. Medication reconciliation is a major issue in care transition management. Medication errors are one of the most common types of patient safety errors and result from poor communication at the time of admission, discharge and/or transfer (Santell, 2006). A detailed list of medications made available to the next setting upon admission is valuable information and could prevent unnecessary hospitalizations resulting from medication-related adverse events. Facilitating transfers in this way would also lead to improvement in quality of care. Furthermore, collecting this information for patients as they transition through settings of post-acute care allows for an understanding of changes from admission to discharge in patient severity and outcomes.

3.3.6 Allergies and Adverse Drug Reactions

The discharge version of the CARE tool also includes items on patient allergies and adverse drug reactions as this information is critical in safe care transitions and in assuring continuity of care. A core item of the tool asks whether the beneficiary has any allergies or known adverse drug reactions. If the answer is yes, there are eight lines to record the specific allergies or cause of reaction and the patient reaction. The availability of this information may increase efficiencies and improve quality of care.

3.3.7 Skin Integrity: Pressure Ulcers and Major Wounds

Skin integrity can be a major source of complications, affecting resource needs and patient outcomes. The CARE tool includes two core items recording whether the patient is at risk of developing pressure ulcers and whether they have one or more unhealed pressure ulcers at stage 2 or higher. The tool also includes a core item on major wounds. Supplemental items ask patients who have these skin integrity problems to describe the severity of the ulcer and wounds. Past studies have shown that chronic, persistent wounds can interfere with activities of daily living and lead to severe pain and slow recovery from comorbid conditions. These characteristics of pressure ulcers and other major wounds can often require significant nursing resources for wound management (Bates-Jensen, 2001; Bates-Jensen, 1999).

The purpose of the skin integrity section of the CARE tool is to collect information on the following items related to pressure ulcers and other major wounds. The pressure ulcer items were developed by a CMS workgroup including representatives from the Wound, Ostomy, and Continence Nurses (WOCN) and the National Pressure Ulcer Advisory Panel (NPUAP). These

are being tested in the MDS 3.0, OASIS-C, and CARE tool efforts. The items in this section measure the following:

- Pressure ulcer risk
- Presence of unhealed pressure ulcers by stage
- Appearance of new ulcers during stay
- Unhealed pressure ulcers present for extended periods of time (over a month)
- Size of pressure ulcers
- Presence of tunneling
- Presence of major wounds
- Type of major wound (e.g., nonhealing surgical wound, trauma-related wound, diabetic foot ulcer, vascular ulcer)
- Turning surfaces with pressure ulcers or major wounds

The above items provide detailed information regarding the number and severity of the pressure ulcers and/or other major wounds. Severity of the wound is captured through wound staging, wound size, the presence of tunneling, and the number of turning surfaces with a major wound. The presence of a major wound coupled with knowledge of wound severity will provide an understanding for resource utilization relating to wound care and may assist in predicting resource utilization for future cases. Additionally, the presence and severity of wounds is important to capture on the care tool since it may affect discharge options. Some major wounds require specific treatments or special beds or chairs that may not be available in all discharge settings.

3.3.8 Physiologic Factors

The physiologic factors captured in the CARE tool include anthropometric measures, vital signs, and laboratory measures. Individual physiologic factors captured on the CARE tool are listed in ***Table 3-4*** along with the justification for the measure's inclusion on the CARE tool.

Physiologic factors are important component measures for understanding patient severity and patient stability as well as predicting discharge options. In an LTCH study, Gage and colleagues also found that collection of some physiologic factors such as respiratory rates and hemodynamic measures are important for distinguishing resource needs and may affect post-acute care options (Gage, Bartosch, Leung, et al., 2005). These measures are key indicators of patients' medical stability and are components of certain high acuity measurement systems, such as the APACHE system which is commonly used in intensive care settings and may be important indicators for the more complex populations discharged to PAC settings. Although several of the physiologic factors listed on the CARE tool may not be applicable to each patient (i.e., INR for patients not on anticoagulants) nor measured in all health care settings, the information is

Table 3-4
Justification for CARE tool physiologic factors

Physiologic factor	Reason for inclusion on CARE tool
Height and Weight	Height and weight allow for the calculation of BMI, which is indicative of overall health status. Individuals with a higher BMI are more likely to suffer from chronic comorbid conditions such as diabetes or hypertension. The weight measure also indicates patients who are morbidly obese and may require specialized equipment.
Vital Signs: Temperature, Heart Rate, Respiratory Rate, Blood Pressure and O_2 Saturation (Pulse Oximetry)	The CARE tool includes a standard set of vital signs utilized across all health care settings. This information is likely to be readily available and is indicative of severity of illness and resource utilization.
Hemoglobin and Hematocrit	Hemoglobin and hematocrit measurements may identify bleeding issues or anemia and are particularly important to monitor in post surgical patients. These laboratory values provide information on patient severity.
WBC	A white blood cell count (WBC) indicates infection and this lab test is indicative of severity of illness and may predict resource utilization.
HbA1c	HbA1c provides information about the stability of an individual's diabetic condition and may be indicative of resource utilization.
Sodium and Potassium	Electrolytes are monitored frequently, particularly for patients on diuretics. Serious illness can result when a patient's electrolytes are out of balance. These lab values may be predictive of patient health outcomes and resource utilization.
BUN and Creatinine	BUN and creatinine blood tests indicate renal function and therefore severity of illness and may indicate resource utilization.
Albumin	Abnormal albumin levels can indicate inflammation, shock, malnutrition, or dehydration. These conditions are indicative of a patient's severity of illness and resource utilization.
Prealbumin	Prealbumin levels measure liver function and abnormal readings are indicative of patient severity of illness.
INR	INR measures blood clotting for patients on anti-coagulants. Abnormal readings are indicative of patient severity of illness and resource utilization.
Arterial Blood Gases: pH, $PaCO_2$, HCO_3, PaO_2, SaO_2, B.E. (base excess)	Arterial blood gases (ABGs) are conducted on patients with severe respiratory issues. Therefore the presence of ABG lab values may indicate that a patient is severely ill and may also be indicative of resource utilization.
Left Ventricular Ejection Fraction	Left ventricular ejection fraction measures heart function and is indicative of patient severity of illness.

SOURCE: RTI International.

informative when it is available. The CARE tool specifies that the most recent information available for each of the physiologic factors be recorded along with the date that the measure was taken. If the test was not provided, "NT" for "not tested" is indicated. On certain items, the presence or absence of a recorded item may be as important as the value recorded for the patient. For example, ABGs are not routinely performed on patients, only those with significant respiratory issues. Also, lab values that reflect abnormal conditions may affect discharge

options; for example, patients with a compromised immune system may require different precautions.

Each of the items collected in the current medical items section of the CARE tool contribute to primary goals of the tool. The contribution of each of the items is summarized below in ***Table 3-5.***

3.4 Cognitive Status, Mood, and Pain Items

This section measures patient abilities to interact with the clinicians, understand treatments, and ultimately, achieve good outcomes. It contains both measures of cognition which are important for detecting problems, such as delirium or dementias that may be underreported as well as other items that require patient interviews, such as pain presence and screening items for mood problems. Many of the items in this section are supplemental items to measure severity of problems once a core item identifies the presence of a problem. Cognitive impairments and depression are closely associated with worse outcomes, particularly functional outcomes (Burdick, Rosenblatt, Samus, et al., 2005). This section examines these items as potential risk adjusters for examining patient outcomes.

3.4.1 Comatose

This item identifies patients as being severely ill and highly dependent with daily activities. The presence of a persistent vegetative state also precludes patients from responding to the self-report cognitive and behavioral items included in this section. This item is included on the CARE tool to screen for these individuals and instruct the assessor to skip to the observational pain item. It is a core item.

3.4.2 Brief Interview for Mental Status

Measures of mental status, including cognitive function, are an important part of clinical assessment, especially in geriatrics, neurology, and medical rehabilitation. There is not one definition of cognition, but it has been described broadly as "the use or handling of knowledge" and "overall functioning of mental abilities." More specific definitions rely on the results of cognitive testing including recall, memory, concentration, and reasoning. There are a large number of cognitive screening questionnaires, diagnostic instruments, and neuropsychological tests, but some of these tests require specialized clinical training to administer and interpret (McDowell, 2006).

For the CARE tool, the workgroup sought a brief performance-based assessment that could be administered by any trained clinician. The core items needed to screen for cognitive impairment while limiting provider burden.

Table 3-5
Current medical items: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS[1]	IRF PPS[2]	HHA PPS[3]
A. Primary Diagnosis							
A1. Primary Diagnosis	Yes	Yes	Yes	Yes	—	Yes	Yes
A2. ICD-9 CM	Yes	Yes	Yes	Yes	—	Yes	Yes
A2a. If primary is V-code, Medical Condition	Yes	Yes	Yes	Yes	—	—	Yes
A2b. ICD-9 CM for A2a	Yes	Yes	Yes	Yes	—	—	—
B. Other Diagnoses, Comorbidities, and Complications							
B1b-B15b. ICD-9 Code	Yes	Yes	Yes	Yes	—	Yes	Yes
B16. If all boxes are used, is list complete?	Yes	Yes	Yes	Yes	—	Yes	Yes
C. Procedures							
C1. Therapeutic or Diagnostic Intervention(s)	Yes	Yes	—	Yes	—	—	—
C1a-C15a. If yes, Procedure Name	Yes	Yes	—	Yes	—	—	—
C1b-C15b. If yes, ICD-9 CM Procedure Code	Yes	Yes	—	Yes	—	—	—
C1c-C15c. If yes, Bilateral Procedure?	Yes	Yes	—	Yes	—	—	—
C16. If all boxes are used, is list complete?	—	—	—	—	—	—	—
D. Treatments							
Insulin Drip	Yes	Yes	—	Yes	—	—	—
Total Parenteral Nutrition	Yes	Yes	—	Yes	Yes	—	Yes
Central Line Management	Yes	Yes	—	Yes	—	—	—
Blood Transfusion(s)	Yes	Yes	—	Yes	Yes	—	—
Controlled Parenteral Analgesia-Peripheral	Yes	Yes	—	Yes	—	—	—
Controlled Parenteral Analgesia-Epidural	Yes	Yes	—	Yes	—	—	—
Left Ventricular Assistive Device (LVAD)	Yes	Yes	—	Yes	—	—	—
Continuous Cardiac Monitoring	Yes	Yes	—	Yes	—	—	—
Chest Tube(s)	Yes	Yes	—	Yes	Yes	—	—
ET Tube Care and Management	Yes	Yes	—	Yes	Yes	—	—
Trach Tube with Suctioning	Yes	Yes	—	Yes	Yes	—	—

(continued)

Table 3-5 (continued)
Current medical items: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS[1]	IRF PPS[2]	HHA PPS[3]
High O2 Concentration Delivery System	Yes	Yes	—	Yes	Yes	—	—
Ventilator-Weaning	Yes	Yes	—	Yes	Yes	—	—
Ventilator- Non-Weaning	Yes	Yes	—	Yes	Yes	—	—
Hemodialysis	Yes	Yes	—	Yes	Yes	—	—
Peritoneal Dialysis	Yes	Yes	—	Yes	Yes	—	—
Fistula or Other Drain Management	Yes	Yes	—	Yes	—	—	—
Negative Pressure Wound Therapy	Yes	Yes	—	Yes	Yes	—	—
Complex Dressing Changes	Yes	Yes	—	Yes	Yes	—	—
Halo	Yes	Yes	—	Yes	—	—	—
Complex External Fixators	Yes	Yes	—	Yes	—	—	—
One-on-One 24-Hour Supervision	Yes	Yes	—	Yes	—	—	—
Specialty Bed	Yes	Yes	—	Yes	Yes	—	—
Multiple IV Antibiotic Administration	Yes	Yes	—	Yes	Yes	—	Yes
IV Vaso-actors	Yes	Yes	—	Yes	Yes	—	Yes
IV Anti-coagulants	Yes	Yes	—	Yes	Yes	—	Yes
IV Chemotherapy	Yes	Yes	—	Yes	Yes	—	Yes
Indwelling Urinary Catheter	Yes	Yes	—	Yes	—	—	Yes
Intermittent Urinary Catheterization	Yes	Yes	—	Yes	—	—	Yes
Ostomy	Yes	Yes	—	Yes	—	—	Yes
External Fecal Management System	Yes	Yes	—	Yes	—	—	—
D1a-D32a. Treatment at Admission (or discharge)	Yes	Yes	—	Yes	—	—	—
D1b-D32b. Used at Any Time During Stay	Yes	Yes	—	Yes	—	—	—
D9c. Reason for Continuous Monitoring	Yes	Yes	—	Yes	—	—	—
D12c. Frequency of Suctioning	Yes	Yes	—	Yes	—	—	—
D23c. Reason for 24-hour Supervision	Yes	Yes	—	Yes	—	—	—

(continued)

Table 3-5 (continued)
Current medical items: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS[1]	IRF PPS[2]	HHA PPS[3]
E. Medications							
E1a-E30a. Medication Name	Yes	Yes	Yes	Yes	—	—	—
E1b-E30b. Dose	Yes	Yes	Yes	Yes	—	—	—
E1c-E30c. Route	Yes	Yes	Yes	Yes	—	—	—
E1d-E30d. Frequency	Yes	Yes	Yes	Yes	Yes	—	—
E1e-E30e. Planned Stop Date	Yes	Yes	Yes	Yes	—	—	—
E31. If all boxes are used, is list complete?	—	—	—	—	—	—	—
F. Allergies and Adverse Drug Reactions							
F1. Any Known Allergies or Reactions?	—	—	Yes	Yes	—	—	—
F1a-F8a. Allergy/Cause of Reaction	—	—	Yes	Yes	—	—	—
F1b-F8b. Patient Reactions	—	—	Yes	Yes	—	—	—
F9. If all lines are used, is the list complete?	—	—	—	—	—	—	—
G. Skin Integrity							
G1. Pressure Ulcer Risk	Yes	Yes	—	Yes	—	—	—
G2. Any Stage 2+ Pressure Ulcers?	Yes	Yes	—	Yes	Yes	—	Yes
G2a-G2d. Number of Pressure Ulcers/Stage 2+	Yes	Yes	—	Yes	Yes	—	Yes
G2e. If Stage 2 :Number of Older Unhealed	Yes	Yes	—	Yes	—	—	—
G3a. Largest Stage 3 or 4 or Eshcar Length in Any Direction	Yes	Yes	—	Yes	—	—	—
G3b. Width of Same Unhealed Ulcer or Eschar	Yes	Yes	—	Yes	—	—	—
G3c. Most Recent Measurement Date of Same Ulcer or Eschar	Yes	Yes	—	Yes	—	—	—
G4. If Stage 3 or 4, Tunneling	Yes	Yes	—	Yes	—	—	—
G5. Any Major Wounds (non-pressure ulcer)	Yes	Yes	—	Yes	Yes	—	Yes
G5a-G5e. Number of Major Wounds	Yes	Yes	—	Yes	Yes	—	Yes
G6a-G6d. Turning Surfaces Not Intact	Yes	Yes	—	Yes	Yes	—	—

(continued)

Table 3-5 (continued)
Current medical items: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS[1]	IRF PPS[2]	HHA PPS[3]
H. Physiologic Factors							
Height (in)	Yes	Yes	Yes	Yes	—	—	—
Height (cm)	Yes	Yes	Yes	Yes	—	—	—
Weight (pounds)	Yes	Yes	Yes	Yes	Yes	—	—
Weight (Kg)	Yes	Yes	Yes	Yes	Yes	—	—
Temperature (F)	Yes	Yes	Yes	Yes	Yes	—	—
Temperature (C)	Yes	Yes	Yes	Yes	Yes	—	—
Heart Rate (beats/min)	Yes	Yes	Yes	Yes	—	—	—
Respiratory Rate (breaths/min)	Yes	Yes	Yes	Yes	—	—	—
Blood Pressure mm/Hg	Yes	Yes	Yes	Yes	—	—	—
Oxygen Saturation (Pulse Oximetry %)	Yes	Yes	Yes	Yes	—	—	—
Hemoglobin (gm/dL)	Yes	Yes	Yes	Yes	—	—	—
Hematocrit (%)	Yes	Yes	Yes	Yes	—	—	—
WBC (K/mm^3)	Yes	Yes	Yes	Yes	—	—	—
HbA1c (%)	Yes	Yes	Yes	Yes	—	—	—
Sodium (mEq/L)	Yes	Yes	Yes	Yes	—	—	—
Potassium (mEq/L)	Yes	Yes	Yes	Yes	—	—	—
BUN (mg/dL)	Yes	Yes	Yes	Yes	—	—	—
Creatinine (mg/dL)	Yes	Yes	Yes	Yes	—	—	—
Albumin (gm/dL)	Yes	Yes	Yes	Yes	—	—	—
Prealbumin (mg/dL)	Yes	Yes	Yes	Yes	—	—	—
INR	Yes	Yes	Yes	Yes	—	—	—
pH	Yes	Yes	Yes	Yes	—	—	—
PaCO2 (mm/Hg)	Yes	Yes	Yes	Yes	—	—	—
HCO3 (mEq/L)	Yes	Yes	Yes	Yes	—	—	—
PaO2 (mm/Hg)	Yes	Yes	Yes	Yes	—	—	—

(continued)

Table 3-5 (continued)
Current medical items: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS[1]	IRF PPS[2]	HHA PPS[3]
SaO2 (%)	Yes	Yes	Yes	Yes	—	—	—
B.E. (mEq/L)	Yes	Yes	Yes	Yes	—	—	—
Left Ventricular Ejection Fraction (%)	Yes	Yes	Yes	Yes	—	—	—
H1a-H28a. Date	Yes	Yes	Yes	Yes	—	—	—
H1b-H28b. Value	Yes	Yes	Yes	Yes	—	—	—
H1c-H28c. Check if Not Tested	—	Yes	Yes	Yes	—	—	—
H1d-H4d. Estimated Value	—	—	—	Yes	—	—	—

[1] The MDS 2.0 collects information on dehydration, delusions, hallucinations, internal bleeding, vomiting, weight loss, and parenteral or enteral intake. Additional treatments collected by the MDS 2.0 include pressure relieving devices for the chair or bed, turning/repositioning programs, nutrition or hydration intervention to manage skin problems, application of ointments/medications (other than to feet), other preventative or protective skin care (other than to feet), and radiation. Finally, the MDS 2.0 collects information on types of therapies received including speech therapy, occupational therapy, physical therapy, and respiratory therapy and any therapies ordered in the first 14 days of stay. All of these items are used in the SNF PPS.

[2] The IRF-PAI collects information on the impairment group, defined as the condition requiring admission to rehabilitation. This item is used in the IRF PPS.

[3] The OASIS collects information on the severity of each of the diagnoses using a scale of 0-4. The OASIS also collects information of the following treatments: parenteral nutrition, enteral nutrition, and intravenous or infusion therapies. These items are used in the HHA PPS.

SOURCE: RTI International.

The Brief Interview for Mental Status (BIMS) is a performance-based assessment for measuring mental status. The BIMS includes items measuring the following:

- Ability to repeat three words
- Temporal orientation
- Recall

The BIMS items are important cognitive impairments and can be used to understand patient severity and measure health outcomes. Patients with severe cognitive impairments may have higher health care resource utilization and these impairments can affect the progress of treatment provided for other conditions (Callahan, Unverzagt, Hui, et al., 2002). Cognitive impairments in elderly medical inpatients also have been documented as a predictor for discharge to SNFs (Joray, Wietlisbach, and Bula, 2004).

The BIMS items on the CARE tool are adapted from the items on the MDS 3.0 for skilled nursing facilities. Minor adaptations to these items were made in order to make them relevant to populations of patients seen in the full range of post-acute care providers. A core screening item asks if the patient was interviewed, and if not, the reason they were not. If a patient is incapable of answering the questions (either verbally or in writing), then an observational assessment is administered which includes items about the patient's observed memory/recall ability.

For patients who can be interviewed, the temporal orientation item, which is commonly used in all acute settings, serves as a core screening item for hospital discharges. Patients who have difficulty answering this item trigger the CAMs supplemental item (see below). For patients admitted to a PAC setting, the complete BIMS is administered at the time of admission. It is used as risk adjuster and not an outcome measure in this population.

3.4.3 Confusion Assessment Method

Delirium, an acute decline in attention and cognition, is a life-threatening and potentially preventable syndrome that is common among hospitalized elderly (Inouye, 2006). The Confusion Assessment Method (CAM) is one method for identifying possible delirium. It has been identified as the best tool for assessing delirium quickly and accurately with a sensitivity of 94 to 100 percent and specificity of 89 to 95 percent (Waszynski, 2007). The CAM has been widely used for assessing elderly hospitalized patients at high-risk for delirium. This set of items also appears on the MDS 3.0. It has been tested and validated in hospital populations and includes items measuring the following:

- Inattention
- Disorganized thinking
- Altered level of consciousness/alertness
- Psychomotor retardation

Measuring delirium is important for understanding patient severity as it may affect outcomes. Identifying delirium can be difficult, so providing information about a patient's history of delirium to the next setting of care is valuable during care transitions. According to

recent research, delirium affects between 25 and 60 percent of older hospitalized patients and has been known to be associated with an increased likelihood of SNF admission and other institutional placement, higher costs, increased length of stay, and functional and cognitive decline (Waszynski, 2007; Kiely, Bergmann, Jones, et al., 2004; Marcantonio, Simon, Bergmann, et al., 2003; Ely, Margolin, Francis, et al., 2001; Inouye, Rushing, Foreman, et al., 1998). The CAM items are collected at the time of an acute care discharge if the patient has difficulty answering the orientation questions correctly. CAM items may also be administered at the time of a PAC admission if responses to the orientation questions are incorrect.

3.4.4 Behavioral Signs and Symptoms

Measures of behavioral signs and symptoms are important to include on the CARE tool since they may affect a patient's ability to comply with a treatment regimen and may influence outcomes. The behavioral signs and symptoms items may also be used to understand resource utilization and some behaviors may limit post-acute care discharge options. For example, the need for 24-hour one-on-one supervision for patients with self-injurious behaviors may not be available in all care settings. Information on behavioral signs and symptoms is collected for the three categories of behavior described below. These items were adapted from the MDS 3.0 and are collected at the time of PAC admission and PAC discharge:

- Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing)
- Verbal behavioral symptoms directed towards others (e.g., threatening, screaming, at others)
- Other disruptive or dangerous behavioral symptoms not directed towards others (including self-injurious behaviors)

3.4.5 Mood

The mood items on the CARE tool include items from the Patient Health Questionnaire-2 (PHQ-2), which is a validated depression screening tool for older populations (Li, Friedman, Conwell, et al., 2007; Kroenke, Spitzer, and Williams, 2003), and items from the NIH PROMIS initiative. Mood items are included on the CARE tool because they are predictive of resource utilization and may affect outcomes. Patients with depression have been reported to receive two to four times as much nonpsychiatric care as patients without depression (Pearson, Patzelnick, Simon, et al., 1999). Depression is also an important comorbidity which can affect outcomes. These are only asked in the PAC populations since measuring them at the time of discharge from acute hospital was considered problematic from a quality of care standpoint.

The PHQ-2 screening items ask if a patient has had little interest in doing things in the past 2 weeks and if the patient is feeling down, depressed, or hopeless. This item is included in the MDS 3.0 as is the longer PHQ-9 item set.

An alternative measure is taken from the PROMIS initiative which uses self-report items to identify patient outcomes. This item has high predictive validity (Cella, Yount, Rothrock, et al., 2007) and asks how frequently in the past 2 weeks the patient has felt sad. The item received mixed feedback when applied to populations who were all recently hospitalized. Questions were raised about its face validity with these populations.

3.4.6 Pain

Self-report is accepted as the most reliable source of data on pain, even though there are limitations (Hadjistavropoulos, Herr, Turk, et al., 2007). The CARE tool includes items measuring three domains of pain: presence of pain, severity of pain, and effect of pain on function. For patients suffering from pain, the severity of pain is measured using the zero to ten scale.

Pain in an elderly population is often overlooked, underassessed, and misassessed, especially when the patient has dementia (Hadjistavropoulos, Herr, Turk, et al., 2007). However, identifying the presence and severity of pain is important for understanding patient severity of illness and resource utilization. A decline in pain has also been used to assess the quality of care provided in an institution (Johnson, Holthaus, Harvell, et al., 2002).

When a patient cannot respond to questions about pain, an observational assessment of pain can be performed where the assessor rates level of pain based on nonverbal sounds, vocal complaints, facial expressions, or protective body movements or postures.

Pain data, either the self-report data or observational assessment data, are considered core items and are collected at acute care discharge and at admission and discharge in PAC.

Each of the items collected in the Cognitive Status, Mood, and Pain section of the CARE tool contribute to at least one of the primary goals of the tool. The contribution of each of the cognitive items is summarized below in ***Table 3-6.***

3.5 Impairment Items

Impairment items are important measures of patient severity and resource utilization. According to the disablement model developed by Nagi, *impairment* is defined as any loss or abnormality of anatomic, physiologic, mental, or emotional structure or function. These may or may not result in functional performance limitations. This section opened in the earlier versions of the tool with one general screening question asking if the patient had any impairments in these areas. It was a gross screening tool that allowed use of one core item instead of a series of core screening items. Later versions of the CARE tool changed this to have unique screening items for each type of impairment. This allowed assessors to measure areas of impairment without having to measure the entire set of impairments which increased the tool's efficiency. Individual sections measure impairments in bladder and bowel management, swallowing, hearing/vision/communication, upper extremity range of motion, weight-bearing restrictions, grip strength, respiratory status, and endurance.

3.5.1 Bladder and Bowel Management

Bladder and bowel management can be predictive of resource utilization and outcomes. A patient with frequent incontinence and need for assistance in managing these issues will require more resources. The items in this section measure the following:

- Presence of an external or indwelling device (for bladder or bowel)
- Frequency of incontinence

Table 3-6
Cognitive items: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS[1,2]	IRF PPS	HHA PPS
A. Comatose							
A1. Persistent Vegetative State	Yes	Yes	—	Yes	Yes	—	—
B. Brief Interview for Mental Status							
B1. Interview Attempted	—	—	—	—	—	—	—
B1a. If no, reason interview not attempted	—	—	—	—	—	—	—
B2. Repetition of Three Words	Yes	Yes	—	Yes	—	—	—
B3a-B3b. Temporal Orientation	Yes	Yes	—	Yes	—	—	—
B4a-B4c. Recall	Yes	Yes	—	Yes	—	—	—
C. Observational of Cognitive Status							
C1. Short Term Memory	Yes	Yes	Yes	Yes	Yes	—	—
C2. Long Term Memory	Yes	Yes	Yes	Yes	—	—	—
C3a-Ce. Memory/Recall Ability	Yes	Yes	Yes	Yes	—	—	—
C4. Cognitive Reasoning	Yes	Yes	Yes	Yes	Yes	Yes	—
D. Confusion Assessment Method							
D1. Inattention	Yes	—	Yes	Yes	—	—	—
D2. Disorganized Thinking	Yes	—	Yes	Yes	—	—	—
D3. Altered Level of Consciousness/Alertness	Yes	—	Yes	Yes	—	—	—
D4. Psychomotor Retardation	Yes	—	Yes	Yes	—	—	—
E. Behavioral Signs and Symptoms							
E1. Physical	—	Yes	—	Yes	Yes	—	—
E2. Verbal	—	Yes	—	Yes	Yes	—	—
E3. Other	—	Yes	—	Yes	Yes	—	—
F. Mood							
F1. Interview Attempted	Yes	Yes	Yes	Yes	—	—	—
F2a-F2d. PHQ2	Yes	Yes	Yes	Yes	Yes	—	—
F3. Feeling Sad	Yes	Yes	Yes	Yes	Yes	—	—

(continued)

Table 3-6 (continued)
Cognitive items: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS[1,2]	IRF PPS	HHA PPS
G. Pain							
G1. Interview Attempted	—	—	—	—	—	—	—
G2. Pain Presence	Yes	Yes	Yes	Yes	—	—	—
G3. Pain Severity 0-10	Yes	Yes	Yes	Yes	—	—	—
G4. Pain Severity Verbal Descriptor	Yes	Yes	Yes	Yes	—	—	—
G5a-G5b. Pain Effect on Function	Yes	Yes	Yes	Yes	—	—	Yes
G6a-Ge. Observed Pain	Yes	Yes	Yes	Yes	—	—	—

[1] The MDS 2.0 collects information on verbal expressions of distress, these include: resident made negative statements, repetitive questions, repetitive verbalizations, persistent anger with self or others, self deprecation, expressions of what appear to be unrealistic fears, recurrent statements that something terrible is about to happen, repetitive health complaints, repetitive anxious complaints/concerns, unpleasant mood in morning, insomnia/change in usual sleep pattern, sad or pained worried facial expressions, crying or tearfulness, repetitive physical movements, withdrawal from activities of interest, and reduced social interaction. The MDS 2.0 also collects information on activity pursuit patterns such as time awake. All of these items are used in the SNF PPS.

[2] The MDS 2.0 collects additional behavioral symptoms such as wandering, socially inappropriate/disruptive behavior, and resistance of care. These items are used in the SNF PPS.

SOURCE: RTI International.

- Need for assistance to manage equipment or devices
- History of incontinence

Bladder and bowel management and impairment items are also important to communicate during care transitions to assure appropriate continuity of care. Knowledge of the presence of bladder and bowel impairments at the time of transition would be useful to the admitting facility so that appropriate resources can be made available and appropriate care can be delivered to the patient.

3.5.2 Swallowing

A patient's ability to swallow is predictive of resource utilization and post-acute care discharge placement. Dysphagia, or difficulty with swallowing, is associated with increased morbidity and in some cases mortality. Management and prevention of aspiration and medical complications for patients with dysphagia is important for positive health outcomes (Palmer, Drennan, and Baba, 2000).

Two swallowing items are included in the CARE tool. The first swallowing item is based on input from the American Speech Language Hearing Association and asks the assessor to identify signs and symptoms of a possible swallowing disorder including complaints of difficulty or pain with swallowing, coughing or choking during meals, holding food in mouth, or loss of liquids or solids from mouth when eating and drinking.

The second swallowing item is based on the science behind the IRF-PAI tool and has the assessor describe the patient's usual ability with swallowing regular food, modified food consistency, or tube/parenteral feeding. Patients with a swallowing disorder may require supervision during meals, modified food consistency, or equipment and assistance for tube feeding. These levels of swallowing disorder represent varying levels of increased resource utilization and it may not be possible to provide the necessary assistance in all post-acute care settings.

Dysphagia is also important to communicate at the time of care transition. Knowledge of the presence of dysphagia at time of transfer will be useful to the admitting site to avoid adverse events and complications common in elderly patients with dysphagia.

3.5.3 Hearing, Vision, and Communication Comprehension

The hearing, vision, and communication comprehension items on the CARE tool include four items taken from the MDS 3.0:

- Understanding verbal content
- Expression of ideas and wants
- Ability to see in adequate light
- Ability to hear

The goal of these items is to identify the level of impairment as mild or moderately impaired, severely impaired, or not impaired. Levels of impairment are assessed with hearing

aids, glasses, or other assistive devices that the beneficiaries may use. These items indicate the presence or absence of a problem and the identification of a problem will lead to further assessment. These items are included in the tool because they are predictive of resource utilization and are important to communicate during care transitions.

3.5.4 Upper Extremity Range of Motion

Upper extremity range of motion was originally included on the tool because this item is predictive of resource utilization and post-acute care discharge placement. The item measures whether or not a patient's active range of motion is within normal limits or if there is limited range of motion. Active range of motion is measured separately for the left shoulder, the left elbow, the right shoulder, and the right elbow. The final version of the proposed tool eliminated this item because the upper body dressing item included in the functional limitations section captures upper body range of motion. Upper body dressing is in the current IRF-PAI system as an indicator of upper body range of motion.

3.5.5 Weight-bearing

The weight-bearing item measures whether or not a patient is fully weight-bearing in the left upper extremity, right upper extremity, left lower extremity, and right lower extremity. The ability to weight bear is important to capture because it related to a patient's ability to use assistive devices and need for assistance in performing surface-to-surface transfers. This item is predictive of resource utilization and may also be predictive of post-acute care discharge options since a patient's inability to weight-bear will require significant staffing resources to provide assistance.

3.5.6 Grip Strength

The grip strength item measures a patient's ability to squeeze a caregiver's hand with each of their own hands. Response categories include normal, reduced/limited, or absent. This item is included in the tool as a measure of frailty and severity of illness.

3.5.7 Respiratory Status

The respiratory status item asks whether a patient was dyspneic or noticeably short of breath during the 2-day assessment period. Response categories are as follows:

- Severe, with evidence the patient is struggling to breathe at rest
- Mild at rest
- With minimal exertion
- With moderate exertion
- When climbing stairs
- Never, patient was not short of breath

Identifying the situation which causes a patient to be out of breath is predictive of patient severity of illness and potential resource utilization.

3.5.8 Endurance

Two endurance items are included on the CARE tool. The first is mobility endurance which asks whether or not a patient had to stop and rest two or more times when walking or wheeling 50 feet in the 2-day assessment period. The second item is sitting endurance which asks if the patient is able to tolerate sitting at the edge of the bed for three minutes. Endurance is important to capture in the CARE tool because patients without endurance are unlikely to be discharged to a rehabilitation setting where treatment includes hours of physical therapy. This item will be used to predict resource utilization and post-acute care discharge placement.

3.5.9 Mobility Devices and Aids Needed

The presence of mobility devices and aids is also included in the CARE tool. The item has patients indicate all mobility devices and aids used including the following:

- Cane/crutch
- Walker
- Orthotics/prosthetics
- Wheelchair/scooter full time
- Wheelchair/scooter part time
- Mechanical life required
- Other

This item will be used to inform resource utilization and patient outcomes.

Each of the items collected in the Impairments section of the CARE tool contribute to at least one of the primary goals of the tool. The contribution of each of the impairment items is summarized below in ***Table 3-7.***

3.6 Functional Status

3.6.1 Core Function Items: Self-care and Functional Mobility

The CARE tool includes a core set of six self-care items and five functional mobility items that will be asked of all patients. This core set of items will be used to evaluate all patients, regardless of functional level. These items include basic self-care activities such as eating, tube feeding, oral hygiene, toilet hygiene, and upper and lower body dressing. The items represent a range of difficulty. Including items with a broad range of difficulty is important for understanding the significant variation in functional status for patients in acute and post-acute care settings. Many of these items are based on the science behind existing items on the OASIS, MDS 3.0, IRF-PAI, and COCOA-B. These items have been shown to work well and are easily scored on existing tools. They also play a role clinically in discharge planning decisions. CARE item text and structure were tailored to the range of patients that will be assessed using the CARE tool.

Table 3-7
Impairments: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS[1]	IRF PPS	HHA PPS[2]
A. Impairments							
A1. Any Impairment	—	—	—	Yes	—	—	—
B. Bladder and Bowel Management							
B1a-B1b. Use of External or Indwelling Device	—	Yes	—	Yes	—	Yes	Yes
B2a-B2b. Frequency of Incontinence	—	Yes	—	Yes	—	Yes	Yes
B3a-B3b. Assistance Managing Bowel/Bladder	—	Yes	—	Yes	—	Yes	—
B4. If incontinent, history of incontinence	—	Yes	—	Yes	—	Yes	—
C. Swallowing							
C1a-C1g. Swallowing Disorder (1)	—	Yes	—	Yes	—	—	—
C2a-C2c. Swallowing Disorder (2)	—	Yes	—	Yes	—	—	—
D. Hearing, Vision, and Communication Comprehension							
D1. Understanding Verbal Content	—	Yes	—	Yes	—	Yes	—
D2. Expression of Ideas and Wants	—	Yes	—	Yes	Yes	Yes	—
D3. Ability to See in Adequate Light	—	Yes	—	Yes	—	Yes	Yes
D4. Ability to Hear	—	Yes	—	Yes	—	Yes	—
E. Upper Extremity Range of Motion							
E1a-E1d. Range of Motion	—	Yes	—	Yes	—	—	—
F. Weight-bearing Restrictions							
F1a-F1d. Weight Bearing Restriction	—	Yes	—	Yes	—	—	—
G. Grip Strength							
G1a-G1b. Grip Strength	—	Yes	—	Yes	—	—	—
H. Respiratory Status							
H1. Respiratory Status	Yes	Yes	—	Yes	—	—	Yes
I. Endurance							
I1. Mobility Endurance	—	Yes	—	Yes	—	—	—
I2. Sitting Endurance	—	Yes	—	Yes	—	—	—
J. Mobility Devices and Aides Needed							
Ja-Jf. Indicate all Mobility Devices and Aides Needed	—	—	—	—	—	—	—

[1] The MDS 2.0 collects information specifically about the existence of a toileting plan or a bladder retraining program. These items are currently used in the SNF PPS.

[2] The OASIS-B items for bowel incontinence frequency and use of ostomy are used in the HHA PPS.

SOURCE: RTI International.

The core items are rated using a six-level rating scale measuring the patient's need for assistance. Rating scale levels include dependent, substantial/maximal assistance, partial/moderate assistance, supervision or touching assistance, setup or clean-up assistance, or independent. The primary purpose of each of the function items is to understand the potential resource utilization and post-acute care discharge placement as measured through the need for assistance scale. Justifications for the inclusion of each of the core self-care and functional mobility items on the CARE tool are provided in ***Table 3-8***.

3.6.2 Functional level

In addition to the core function items that will be asked of all patients, more specific function items will be administered to patients who are being discharged to post-acute care for improving their functional ability or who will need personal assistance following discharge. These items will be used to measure severity within the different core impairment areas. This approach is intended to minimize burden while maximizing the range of patient ability captured (i.e., avoiding floor and ceiling effects).

Having a core set of information on all patients and as well as a more specific set of information based on a patient's general level of function will allow for a more accurate understanding of a patients level of function across. The 25 supplemental items address a range of activities from the least difficult such as sponge bathing and rolling left to right to the most difficult activities such as driving or using public transportation. Only items that patients participate in and can be observed will be assessed. The 25 supplemental items are as follows:

- Wash upper body
- Shower/bathe self
- Roll left or right
- Sit to lying
- Picking up object
- Putting on/taking off footwear
- Wheelchair use for mobility
- 1 step (curb)
- Walk 50 feet with two turns
- 12 steps interior
- 4 steps exterior
- Walk 10 feet on uneven surface
- Car transfer
- Wheelchair users only—short ramp
- Wheelchair users only—long ramp
- Telephone—answering
- Telephone—placing call

Table 3-8
Justification for CARE tool core self-care and functional mobility items

Self-care item	Reason for inclusion on the CARE tool
Eating	Eating measures the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table or tray and also includes modified food consistency. Patients requiring higher levels of assistance may have higher resource utilization and this may also affect post-acute care discharge placement.
Tube Feeding	Tube feeding includes the ability to manage all equipment and supplies for tube feeding. Patients requiring higher levels of assistance may have higher resource utilization and this may also affect post-acute care discharge placement. The supervision required for patient with substantial assistance may not be available in all settings. The tube feeding item is distinct from both the swallowing item and the eating item because patients who are able to manage the feeding tube on their own will be rated as independent and may require additional resources.
Oral Hygiene	The oral hygiene item is included because it is an activity that all patients need to perform. Patients requiring higher levels of assistance may have higher resource utilization.
Toilet Hygiene	Patients requiring higher levels of assistance may have higher resource utilization and this may also affect post-acute care discharge placement.
Upper body dressing	Upper body dressing includes the ability to put on and remove shirt or pajama top, including buttoning three buttons. This item measures upper body mobility and fine motor skills. Patients requiring higher levels of assistance may have higher resource utilization.
Lower body dressing	Lower body dressing includes the ability to dress and undress below the waist, including fasteners. This item measures lower body mobility, balance, and dexterity. Similar to the upper body dressing item, patients requiring higher levels of assistance may have higher resource utilization.
Lying to Sitting on Side of Bed	This is a lower level function item. Need for assistance with this item is indicative of resource utilization and may also affect post-acute care discharge placement.
Sit to Stand	This item measures balance and transition and is a more difficult function item that may be used to assess fall risk. Need for assistance with this item is indicative of resource utilization.
Toilet Transfer **Chair/Bed-to-Chair Transfer**	Both toilet transfer and chair-to-chair transfer are included in the CARE tool. Chair-to-chair transfer is a more basic surface-to-surface transfer, but toilet transfer is more difficult because it occurs in a constrained space. Toilet transfer is predictive of a patient's ability to return home. For both items, patients requiring higher levels of assistance may have higher resource utilization and this may also affect post-acute care discharge placement.
Longest distance the patient can walk	The walking items codes the longest distance the patient can walk. This is a performance based item and the response categories include Walk 150 ft, Walk 100 ft, Walk 50 ft, or Walk in room once standing. This locomotion item is predictive of post-acute discharge placement and resource utilization. Patients with limited mobility requiring higher levels of assistance may have higher resource utilization.
Longest distance the patient can wheel	For patients whose primary mode of mobility is wheelchair, there is a locomotion item that corresponds to the walking item. The wheelchair items codes the longest distance the patient can wheel. This is a performance based item and the response categories include Wheel 150 ft, Wheel 100 ft, Wheel 50 ft, or Wheel in room once sitting. This locomotion item is predictive of post-acute discharge placement and resource utilization. Patients with limited mobility requiring higher levels of assistance may have higher resource utilization.

SOURCE: RTI International.

- Medication management—oral medications
- Medication management—inhalant/mist medications
- Medication management—injectable medications
- Make light meal
- Wipe down surface
- Light shopping
- Laundry
- Use public transportation

Each of the items collected in the Functional Status section of the CARE tool contribute to at least one of the primary goals of the CARE tool. The contribution of each of the functional status items is summarized below in ***Table 3-9.***

3.7 Engagement

The CARE tool originally proposed collecting information on the patient's level of engagement in their treatments. This item asked the assessor to indicate the patient's cognitive and emotional resources to comprehend hospital environment, tolerate typical frustrations of the setting, and participate actively in the program. The seven level response scale ranged from no problem to severe problems and is based on the RIC-FAS assessment items. This item is included in the CARE tool because it is predictive of patient outcomes. Patients who are not engaged in their treatment may not be compliant and may not have successful outcomes. This item may also be predictive of resource utilization if the lack of patient engagement leads to poor health outcomes that require further treatment. This item is also predictive of post-acute care setting because patients refusing to participate with interventions are not likely to be discharged to a rehabilitation facility where intensive therapy is required. This item was later deleted as it had not been tested extensively on any population.

3.8 Frailty/Life Expectancy

Two items measuring frailty were also originally included in the CARE tool. The first item asks the assessor if it would be a surprise if the patient was readmitted to an acute care hospital in the next 6 months and the second asks if it would be a surprise if the patient were to die in the next 12 months. These items are included because they may be indicative of patient severity of illness and resource utilization. They have been adapted from items used in the British Gold Standards Framework Programme (NHS, 2005). A frail patient is likely to be readmitted to an acute hospital and have higher resource utilization. A similar item is contained in the OASIS-B tool although it has limited response rates in the national sample. This was a controversial item as some feared that they would be held liable for making judgments about a patient's expected recovery that were not based on significant evidence. These items were omitted from the final version of the tool.

Table 3-10 summarizes the reasons for inclusion of both engagement and frailty/life expectancy items on the CARE tool. Both of these sets of items satisfy at least one of the main goals of the CARE tool.

Table 3-9
Functional status: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS	IRF PPS	HHA PPS
A. Self-Care							
A1. Eating	Yes	Yes	Yes	—	Yes	Yes	—
A2. Tube Feeding	Yes	Yes	Yes	—	—	—	—
A3. Oral Hygiene	Yes	Yes	Yes	—	—	Yes	—
A4. Toilet Hygiene	Yes	Yes	Yes	—	Yes	Yes	Yes
A5. Upper Body Dressing	Yes	Yes	Yes	—	—	Yes	Yes
A6. Lower Body dressing	Yes	Yes	Yes	—	—	Yes	Yes
B. Core Functional Mobility							
B1. Lying to Sitting on Side of Bed	Yes	Yes	Yes	—	Yes	—	—
B2. Sit to Stand	Yes	Yes	Yes	—	Yes	Yes	—
B3. Chair/Bed-to-Chair Transfer	Yes	Yes	Yes	—	Yes	Yes	Yes
B4. Toilet Transfer	Yes	Yes	Yes	—	Yes	Yes	Yes
B5. Mode of Mobility	Yes	Yes	Yes	—	—	—	—
B5a. Longest Distance Patient Can Walk	Yes	Yes	Yes	—	—	—	—
B5b. Longest Distance Patient Can Wheel	Yes	Yes	Yes	—	—	—	—
C. Supplemental Functional Ability: Code patient on all activities that the patient can participate in and which you can observe.							
C1. Sponge Bath	Yes	Yes	Yes	—	—	Yes	—
C2. Shower/Bathe Self	Yes	Yes	Yes	—	—	Yes	Yes
C3. Roll Left or Right	Yes	Yes	Yes	—	Yes	—	Yes
C4. Sit to Lying	Yes	Yes	Yes	—	Yes	—	—
C5. Picking Up Object	Yes	Yes	Yes	—	—	—	—
C6. Mode of Mobility: Wheelchair?	Yes	Yes	Yes	—	—	Yes	—
C6a. One Step (curb)	Yes	Yes	Yes	—	—	—	—
C6b. Walk 50 Feet with 2 Turns	Yes	Yes	Yes	—	—	Yes	—
C6c. 12 Steps-Interior	Yes	Yes	Yes	—	—	Yes	—
C6d. 4 Steps-Exterior	Yes	Yes	Yes	—	—	—	—

(continued)

Table 3-9 (continued)
Functional status: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS	IRF PPS	HHA PPS
C6e. Wheelchair Users Only: Short Ramp	Yes	Yes	Yes	—	—	—	—
C6f. Wheelchair Users Only: Long Ramp	Yes	Yes	Yes	—	—	—	—
C7. Telephone-Answering	Yes	Yes	Yes	—	—	—	—
C8. Telephone-Placing Call	Yes	Yes	Yes	—	—	—	—
C9. Medication Management-Oral Medications	Yes	Yes	Yes	—	—	—	—
C10. Medication Management-Inhalant/Mist Medications	Yes	Yes	Yes	—	—	—	—
C11. Medication Management-Injectable Medications	Yes	Yes	Yes	—	—	—	Yes
C12. Make Light Meal	Yes	Yes	Yes	—	—	—	—
C13. Wipe Down Surface	Yes	Yes	Yes	—	—	—	—
C14. Light Shopping	Yes	Yes	Yes	—	—	—	—
C15. Laundry	Yes	Yes	Yes	—	—	—	—
C16. Get in/out of Car	Yes	Yes	Yes	—	—	—	—
C17. Drive a Car	Yes	Yes	Yes	—	—	—	—
C18. Use Public Transportation	Yes	—	Yes	—	—	—	—

SOURCE: RTI International.

Table 3-10
Engagement and frailty/life expectancy: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS	IRF PPS	HHA PPS
Engagement							
A1. Indicate Level of Engagement: 0-6 Scale	Yes	Yes	Yes	—	—	—	—
Frailty/Life Expectancy							
A1. Surprise if Patient was Readmitted in the Next 6 Months	Yes	Yes	Yes	—	—	—	—
A2. Surprise if Patient Died in the Next 12 Months	Yes	Yes	Yes	—	—	—	—

SOURCE: RTI International.

3.9 Overall Plan of Care/Advance Care Directives

In this section, three items are included that identify whether the clinical team has discussed treatment goals with the patient (or their representative), describe the overall prognosis in terms of patient stability and frailty, and identify whether the patient has made and documented future treatment decisions. These items are expected to improve quality of care for patients experiencing potentially life-threatening situations.

3.10 Discharge Status

The items in the discharge status section of the CARE tool focus on a patient's home situation, their need for assistance, and the availability of caregivers. The discharge status items also capture information that may affect their success at discharge, including assessments of their need for assistance with medications and transportation. This section of the tool also documents the potential post-acute care discharge settings that were considered by the clinical team, the availability of those services, the preference of the patient or their family, and whether an option was covered by insurance. These are all factors likely to affect long term outcomes.

The items focusing on the home situation, patient needs, and availability of assistance are predictors of post-acute care discharge options. Patients may not be able to go home if they have limited mobility and live in an apartment without an elevator or if their living space cannot accommodate extra equipment required for their ongoing treatment. Documenting these types of situations will help predict post-acute care discharge placement. Similarly a patient's need for assistance and the availability of caregivers will also affect post-acute care discharge.

Availability of transportation and ability to pay for medications after discharge are also included in the discharge status section of the CARE tool. Availability of transportation is necessary to document because patients without transportation options may not be able to attend post-discharge physician appointments or other outpatient services such as physical therapy for follow-up. This may limit options for post-acute care discharge placement or may trigger the need for home health services. Patients' ability to manage their medications after discharge is important because those who are unable to do so may experience poor health outcomes from not taking medications, and this may result in a re-hospitalization and an increase in resource utilization. Another item in the discharge needs section measures whether the availability of a willing and able caregiver affects discharge options. This item is included in order to better understand the factors that influence the setting that a patient is discharged to.

The discharge care options section of the tool documents any provider that was considered appropriate for discharge placement. Many factors lead to the choice of a post-acute care provider, so in addition to documenting whether the setting was deemed appropriate, this section documents if a bed was available in each setting considered, if the setting was refused by the patient or family, or if a setting was is not covered by insurance. This information will contribute to a better understanding of how post-acute care placement decisions are made.

Additionally, this section of the CARE tool documents the date of discharge, the discharge location, and name and identification number of the provider. Delays in discharge and reason for the delay are also noted in order to fully understand discharge options and placement.

Table 3-11 summarizes the purpose of each of the discharge status items included on the CARE tool in terms of the four main goals of the tool.

Table 3-11
Discharge status: Reason for inclusion in the CARE tool

Item description	Patient severity	Resource use	Outcomes measurement	Continuity of care	SNF PPS	IRF PPS	HHA PPS
A. Discharge Information							
A1. Discharge Date	—	—	—	Yes	—	—	—
A2. Discharge Location	—	—	—	Yes	—	—	—
A3. Frequency of Assistance at Discharge	—	—	Yes	Yes	—	—	—
B. Caregiver Information: If discharged to noninstitutional community setting							
B1a-B1f. Patient Lives with at Discharge	—	Yes	—	Yes	—	—	—
B2. Caregiver Availability	—	Yes	—	Yes	—	—	—
B3a-B3d. Types of Caregivers	—	Yes	—	Yes	—	—	—
C. Other Discharge Needs							
C1. Ability to Pay for Medications	—	Yes	Yes	Yes	—	—	—
C2. Ability to Manage Medications	—	Yes	Yes	Yes	—	—	—
C3. Patient Transportation	—	Yes	Yes	Yes	—	—	—
C4. Does availability of caregivers affect discharge options?	—	—	Yes	Yes	—	—	—
D. Discharge Care Options							
D1a-D1j. Deemed Appropriate by the Provider	—	—	Yes	—	—	—	—
D2a-D2j. Bed/Services Available	—	—	Yes	—	—	—	—
D3a-D3j. Refused by Patient/Family	—	—	Yes	—	—	—	—
D4a-D4j. Not Covered by Insurance	—	—	Yes	—	—	—	—
E. Discharge Information							
E1. Provider Name	—	—	—	Yes	—	—	—
E2. Provider Type	—	—	—	Yes	—	—	—
E3. Provider City	—	—	—	Yes	—	—	—
E4. Provider State	—	—	—	Yes	—	—	—
E5. Medicare Provider Identification Number	—	—	—	Yes	—	—	—
E6. Patient Requests that Information Not be Shared	—	—	—	—	—	—	—
E7. Discharge Delay	—	Yes	—	—	—	—	—
E8. Reason for Discharge Delay	—	Yes	—	—	—	—	—

SOURCE: RTI International

SECTION 4
TECHNICAL EXPERT PANELS

Two technical expert panel meetings were convened at CMS to gather input from the provider and research communities. The goal of these two panels was to collect expert input on the proposed framework and recommended items for the CARE tool. TEP members are listed below and represent the range of the five types of providers expected to use the CARE assessment tool. As with the workgroups, it was important to have input from experts associated with each of the five levels of care so that consideration was given to patients treated in each setting, independent of issues associated with a different level of care. Each member represented an advocate for providing care in at least one of the five settings. The first TEP represented practicing clinicians, providers, or associations representing care or provider certification. The second TEP was comprised of researchers who studied patients treated in at least one of the five settings.

4.1 Technical Expert Panel One Proceedings

An initial set of items was presented to a technical expert panel (TEP) convened at CMS in Baltimore, Maryland, on March 6 and 7, 2007. The purpose of the TEP was to review the range of concepts that the clinical workgroups recommended as being important for explaining differences in resource utilization or monitoring patient outcomes and to discuss their applicability to the wide range of populations included in this effort. This expert panel was comprised of representatives from post-acute care providers and provider associations. Feedback from the TEP led to significant revisions that improved item definitions, clarified instructions, and minimized provider burden.

The TEP meeting was structured to address the five main categories of items included in the tool: social and environmental items, medical items, functional items, cognitive items, and continuity of care items. Four half-day sessions were held to discuss the work of each of the four workgroups. The final session allowed TEP participants to share their take-away messages on the tool with the group.

The TEP members included:

John Brofman, MD
Medical Director
RML Specialty Hospital

Andrew Bohart, MD
Nebraska Internal Medicine, P.C.

Sharon Camhi, MD
Medical Director, Respiratory Care Unit
Assistant Professor of Medicine in the Division of Pulmonary, Critical Care, and Sleep Medicine
Mount Sinai Hospital

Michelle Camicia
Director of Operations
Kaiser Foundation Rehabilitation Center

Margarita Cancio, MD

Shannon Carson, MD
Associate Professor of Pulmonary and Critical Care Medicine
UNC School of Medicine

Dexanne Clohan, MD
Chief Medical Officer and Senior Vice President
HealthSouth Corporation

Gerard Criner, MD
Division of Pulmonary & Critical Care Medicine
Temple University School of Medicine

Jean de Leon, MD
Baylor Specialty Hospital

Bruce Gans, MD
Kessler Institute for Rehabilitation

Chris Hirsch, MD
Administrative Director, Department of Respiratory Care
Maine Medical Center

Donna McFarland
Vice President for Patient Care Services
Mercy Medical Center

Janet Maguire
Nursing Director, Special Care Unit
Maine Medical Center

Sean Muldoon, MD
Kindred Healthcare

Patrick Murray, MD
Center for Healthcare Research and Policy
Department of Physical Medicine and Rehabilitation

Patricia Rice
Select Medical Corporation

Elizabeth Sandel, MD
Chief, Physical Medicine and Rehabilitation, Napa Solano Service Area
Director of Research and Training, Kaiser Foundation Rehabilitation Center

Sharyn Sizemore
Director, Medical Care Management
Sentara Hospitals

John Votto, MD
President and Chief Executive Officer
Hospital for Special Care

The remainder of this section highlights the key discussion points from each of the sessions held during the 2-day TEP meeting.

4.1.1 Social and Environmental Items Session

During this session the social workgroup presented their proposed items to the TEP and requested feedback regarding individual items.

Prior Residence. In general, this item is meant to capture the residential setting of the patient prior to the current episode of care. TEP participants discussed prior residence and clarified some of the terms used in the proposed item. For example, the TEP believed that "onset of this illness or injury" was confusing, particularly for patients suffering from chronic conditions for decades, and it should be changed to a phrase similar to "prior to this hospitalization" or "prior to this acute episode." The TEP recommended the elimination of the term "institution" and reconsideration of the term "permanent." The TEP also suggested that shelters, prisons, and other nontraditional places of residence should be included on the tool to be comprehensive.

Structural Barriers. Structural barriers may exist in discharge settings and may prevent discharge to a specific location. The TEP suggested additional items that could be considered in the structural barrier items (e.g., transportation, lack of electricity, lack of lighting, ground defaults, telephone, and space. One TEP member also suggested that the capacity for adapting or changing structural barriers in a potential discharge location should be captured to fully understand potential discharge destinations.

Prior Lives With. This item captures the presence of informal caregiver support available to a patient. The presence of a spouse has been shown to be highly predictive of home discharge and is therefore of interest for the CARE tool. It was suggested that this item capture this concept more directly instead of only requesting the relationship of the potential caregiver. Furthermore, availability for caregiving may be more meaningful than just knowing "prior lives with." For example, a patient living with an impaired spouse lives with someone but would not receive much assistance from him or her.

Frequency of Assistance. This item is meant to capture the frequency of assistance required for the patient. The TEP suggested that this item should distinguish between different forms of care (e.g., medical vs. informal care and physical vs. supervisory care). The TEP felt that it is possible that this item could affect discharge destinations.

Additional suggestions for the Social and Environmental Items section of the tool included capturing patient preferences for discharge and an item capturing level of independence and spouse impairments. The TEP also proposed that, to limit burden, this item should be restricted only to those who will be discharged to the community.

4.1.2 Medical Items Session

During this session the medical workgroup presented their proposed items to the TEP and requested feedback regarding individual items.

TEP participants and tool development team members discussed whether the Medical Items on the tool were sufficient to predict patient severity and stressed the importance of developing a tool that could cross all post-acute care settings. One of the participants commented that the APR-DRG already does a good job at differentiating between LTCHs and SNFs and that if the goal of the tool is to provide good case-mix/severity illness these items would be useful. There was some hesitation with including the APR-DRGs since these types of "package systems" do not cross fields well and are not refined enough to distinguish between certain settings such as the LTCHs and the acute care hospitals. Some of these case-mix severity of illness systems can be used if the ICD-9 CM codes are collected on the tool.

The TEP discussed the idea of diagnosis check-off boxes versus the collection of ICD-9-CM codes. The TEP was particularly concerned that the collection of ICD-9-CM codes would be more resource intensive, particularly for small hospitals or SNFs that would need to involve professional coders in the assessment process. Additionally, it has been found that providers are not very accurate or careful in selecting the appropriate code among related codes, particularly down at the fifth digit; therefore, ICD-9-CM codes collected through the tool may not be reliable measures of patient severity. The lack of enthusiasm for ICD-9-CM codes was consistent across health care settings, thus the TEP advised that it may be prudent to collect information regarding diagnoses through a check-off list or other method. Some felt that previous studies have shown that collecting ICD-9-CM codes to the fourth and fifth digits do not add much to the understanding of patient severity. However, the IRF, HH, LTCH, and acute hospital payment systems are all based on this level of information. It was felt that if the ICD-9-CM codes became linked to payment for all settings, providers would move towards complete and accurate coding systems.

The diagnosis items on the CARE tool had included primary acute care diagnosis and post-acute care diagnosis. This had raised some concerns with the acute care facilities, in particular, that they would be asked to provide the post-acute care diagnosis. It was stressed that the short-term care physician is only responsible for the short-term acute care diagnosis. Alternative terms for capturing the post-acute care diagnosis at acute care discharge were suggested and included "what is the need for post-acute care" or "what is the working diagnosis." In general, there was concern with having one setting answer questions for other parties/settings. This generates an opportunity for tremendous mismatch.

An additional concern made apparent throughout the discussions was the possibility that the tool may be used to predestinate discharge. The TEP stressed the importance of continuously clarifying the distinction between "predicting" and "predestinating." It should be made clear that the tool will provide better information for considering discharge options but it will not be used to dictate placement. It is important to be confident that a patient will not receive less aggressive rehabilitation program because of some subtle factor that was not considered during the development of the tool. In response to this concern RTI and CMS provided clarification that the tool is not for prescribing setting but rather for making case-mix adjustments for similar patients equivalent across settings.

Active Diagnosis or Treatment. One of the questions posed to the TEP during this session was whether there is a need to differentiate activeness of a diagnosis or treatment or whether a general list of comorbidities and complicating conditions would be sufficient to gather the information needed. The TEP indicated that it is still important to identify a diagnosis as a comorbidity even if it is being effectively managed. Hypertension provides a good example. If a patient has stable blood pressure on two agents it is still important to list hypertension as a comorbidity because this may have some resource implications. Some of these types of diagnoses may also be captured through a listing of medications. The TEP also clarified the tool should restrict the time frame of the comorbidity or complication. For example, the presence of gestational diabetes over 20 years ago will not be informative for the purposes of the CARE tool.

Physiologic Factors. The TEP and the tool development team reviewed the list of physiologic factors that were proposed for inclusion on the CARE tool as well as the instructions for completion. Concerns that arose for the collection of physiologic factors were the availability of this type of information in specific settings, the timing of the measurements, and the difficulties with measurement in some settings. In post-acute care settings the frequency of measurement may be less than in acute care settings and it would be important to specify which measurement would be more informative. Additionally, it may be difficult for some of the items to be measured. For example, height and weight measurements by home health nurses would require measurement tools that may not be available. In this instance it may be helpful if estimates for height and weight were acceptable.

The TEP provided some suggestions for additional physiologic factors that should be captured in this section of the tool. These factors included arterial blood gases and heart rate. The TEP felt that capturing information about morbid obesity through height and weight would be of particular importance since some facilities are not equipped to handle bariatric patients.

Bowel and Bladder Incontinence. The need for assistance with toilet transfer can be very resource intensive. Therefore, it is important for the tool to capture bowel and bladder incontinence. The TEP suggested additional items for bowel and bladder incontinence including a question asking the reason for which a catheter is in place, a question about prolonged constipation, and the presence of an ostomy.

Skin Conditions. The TEP reviewed the pressure ulcer items that had been developed by a CMS workgroup. It was suggested that instead of capturing the size of a single pressure ulcer that the tool development team should consider capturing the total surface area of all pressure ulcers. This would better quantify the burden of care. The TEP discussed the idea of capturing risk for the development of pressure ulcers and agreed that a systematic look at the possible risk factors for pressure ulcers would be a good addition to the tool particularly since formal evaluations of pressure ulcer risk are almost always required for other purposes. While most individuals agree, there was still some concern about this type of assessment in the acute care settings. The TEP also suggested that the skin condition section of the tool should incorporate the presence of stasis ulcers and other nonsurgical wounds.

Life Expectancy/Frailty. There was some confusion over the inclusion of this item on the tool. The question was thought to be more appropriate for a palliative care setting and was not believed to be a good risk adjuster for outcomes since it is very gameable and physicians can

not accurately predict death. Additional concern with the inclusion of this item stemmed from potential liability issues and medical ethics issues. If a patient or family member were to see the response to this item before the physician has spoken to the patient, this could present a major issue. One of the acute care nurses mentioned that it is more than likely that most nurses will leave this item blank unless the response is extremely clear. The TEP discussions indicated that a prognosis item may not be a valuable addition to the tool and that further consideration for inclusion of this item is required.

Treatment. The TEP reviewed the list of treatments that had been proposed for inclusion on the tool. The TEP offered some suggestions for revisions including the deletion of pace maker management and adjustment and the addition of enteral tube feeding. Additionally, the TEP suggested that some qualifications be provided for certain treatments. Negative pressure wound therapy and dressing changes involving two people, for example, may be gameable treatments. The TEP acknowledged that some treatments may be gameable but that there is no real distinct line to indicate or define gameability. For example, for central line insertion and management, the line could easily be left in for some extra time. It was stressed that because of these issues, these items should not be used in payment systems, although they would be useful in outcomes analysis.

Additional suggestions for the Medical Items section of the tool included capturing the patient's likelihood for improvement or improvement prognosis and nonelective surgeries or procedures.

4.1.3 Functional Items Session

During this session the functional workgroup presented their proposed items to the TEP and requested feedback regarding individual items. The functional workgroup also presented the proposed rating scale for all of the items in detail.

The TEP questioned the functional workgroup's confidence in the new questions and rating scale. The workgroup clarified that they were confident in the proposed items because the modifications to existing items were based on research examining legacy instrument performance. Some TEP members were concerned with the "greater than half" and "less than half" terminology and thought that it may be difficult to understand and to train assessors on. Training of appropriate staff members will need to be very thorough for the completion of these function items. The TEP also reiterated the concern with provider burden and suggested that skip patterns be used such that only core items and relevant supplement items need to be completed for any given assessment. It was suggested that a shorter, more crude version of the tool be available in acute care settings. These considerations were incorporated in the later versions of the tool.

Eating Item. The TEP reviewed the terminology used in the eating item and commented on the subtleties of the words chosen. The TEP provided suggestions for rewording the item. Suggestions included removing the use of utensils since the ultimate goal is to get food to the mouth and to remove chewing and swallowing.

Upper Body Mobility. The TEP discussed the inclusion of an appropriate item to capture upper body mobility. One of the concerns of the traditional dressing item is that this would be

too easy in acute care facilities where patients primarily wear hospital gowns. The TEP considered other bimanual items that may be included on this assessment to measure upper body mobility but did not make any final conclusions or suggestions.

Additional suggestions for the Functional Items section of the tool included a low level endurance item, a gait speed item, a shortness of breath item, and documentation of the time associated with completing items.

4.1.4 Cognitive, Pain, and Mood Items Session

During this session the cognitive workgroup presented their proposed items to the TEP and requested feedback regarding individual items.

Mental Status. The TEP reviewed and discussed the Brief Interview for Mental Status (BIMS). Members agreed it was useful, but a specific concern was that a performance-based mental status exam at the time of discharge does not necessarily fit well in the workflow. The delirium items, the Confusion Assessment Method tool, were of particular interest in discussions. Delirium was thought to be an important item to include on the tool since it is associated with poor health outcomes, including mortality. However, without intensive training, item reliability may be poor, particularly for the item related to psychomotor retardation. One geriatrician suggested that inattention could potentially be used as a delirium screener item, but there was no consensus.

Mood/Depression. The TEP reviewed potential mood/depression items, including the Patient Health Questionnaire (PHQ)-9 (nine questions) and PHQ-2 (two questions). It was stressed that depression is an important case-mix adjuster for outcomes so it should be captured on the tool. The collection of these data (at the time of acute care discharge) was a concern to some TEP participants. It did not seem appropriate to be asking these questions at discharge. The TEP agreed that depression should exist as a screener item and that the PHQ-2 would be sufficient.

Behavioral Symptoms. The TEP discussed the behavior item and suggested that items such as the need for chemical restraints be added. The TEP felt that this item was particularly important for inclusion on the tool.

Pain. The TEP members discussed the pain items that should be included on the tool and suggested that the tool include the numeric rating scale (0-10 pain scale). This scale has been widely translated and is easy to use. The TEP had also considered the picture pain scale, but this scale may not be reliable across cultures. There is research suggesting that patients with cognitive impairment may find it easier to respond to a verbal descriptor scale, and so these data will also be collected in the pilot tests.

Sensory Input. The sensory input items indicate the presence or absence of a vision or hearing problem and are therefore important to capture on the tool. The TEP suggested that these items be completed at admission to a post-acute care setting, as they may be inappropriate at discharge.

Fatigue. Fatigue was thought to be an important case-mix adjuster and would be important for the tool. The TEP felt discussed the distinction between fatigue and endurance, and the importance of endurance for patients admitted to inpatient rehabilitation facilities. There were some concerns that endurance is not a term that is frequently used in some settings, but that fatigue is well understood. Ultimately, the group discussed the inclusion of an item measuring level of endurance is more important than fatigue since a fatigued individual may still be able to perform an activity.

Additional suggestions for the Cognitive Items section of the tool included capturing executive function, endurance, and the need or desire for an interpreter

4.1.5 Continuity of Care Session

One of the potential uses of the tool is as a means for assuring continuity of care and seamless care transitions. During the TEP meeting the tool development team provided suggestions for some items that may be useful to collect for transitions. These items were reviewed by the TEP and additional suggestions of a continuity of care section were made. Some TEP participants mentioned that the tool development team should include the entire continuity of care record (CCR) so that the tool becomes more clinically useful. For several other participants, however, this represented a duplication of current discharge practices and represented a significant burden increase.

4.1.6 Take-away Messages

At the close of the TEP meeting each participant was asked to share their main take-away message from the meeting. These messages are summarized below:

- The tool needs to have a user-friendly platform for completion and submission.
- Burden for completion of the tool needs to be minimal and clear guidelines for use need to be made available.
- The tool development team should be aware of the time and resource constraints in acute care facilities and adjust the tool as necessary to include screeners wherever possible.
- The tool should be as core as it can be. It should be parsimonious and truly minimal, not redundant.
- The tool language needs to be streamlined.
- Although the tool is a living form, changes to the tool should be limited as much as possible due to resources spent training staff to complete the assessments.
- The tool should include core continuity of care items that are transferred to the next site of service.
- The tool should be simple and should use existing language wherever possible. The introduction of a new rating scale may cause confusion.
- Clarity will be crucial for buy-in and scientific evidence will be important.

- Differences in settings should be incorporated into the tool, surveillance is important, and the tool needs to ask about the potential benefit/change from treatment.
- Information for the tool should only be collected by individuals professionally capable of collecting the information.
- The medical items section needs more granularity for measuring outcomes in SNFs and LTCHs. In these settings, function is fairly flat but medical issues may be resolved.
- The tool is good for outcomes studies but concerns are lingering regarding the differentiation and placement to specific settings. Predicting settings with the tool will be difficult.
- The tool should capture and address the diversity of both the workforce and the patients.

4.2 Technical Expert Panel Two Proceedings

A second technical expert panel (TEP) convened at CMS in Baltimore, Maryland, on April 17 and 18, 2007. This expert panel was comprised of researchers and clinicians with expertise in assessment instrument design, measurement, and payment policy. The purpose of this TEP was to discuss key concepts for the CARE tool that allow it to measure patient characteristics or predict resource utilization or patient outcomes. RTI and CMS provided TEP members with background materials on item development and led discussions around the major groups of items on the tool, cognitive, functional, medical, and social/environmental. Background materials included item definitions and rating scales from the assessment instruments currently used in post-acute care settings (MDS, IRF-PAI, and OASIS) as well as a set of discussion questions to focus group discussion on key concepts. Feedback from the TEP led to further revisions to improve item definitions, clarify instructions, and minimize provider burden.

TEP members included:

Karen Bankston, PhD, FACHE
Senior Vice President
Drake Center, Inc.

Christine E. Bishop, PhD
Professor and Director, Doctoral Program
Schneider Institute for Health Policy
Brandeis University

Kathryn H. Bowles, PhD, RN
Associate Professor of Nursing
University of Pennsylvania School of Nursing

Gerben DeJong, PhD
National Rehabilitation Hospital

Jean De Leon, MD
Medical Director
Baylor Specialty Hospital

Harry Feliciano, MD, MPH
Director, Part A Medical Affairs
Palmetto GBA

David Hittle, PhD
Assistant Director
Division of Health Care Policy and Research
University of Colorado

Samuel Markello, PhD
Associate Director
Uniform Data Systems for Medical Rehabilitation

Robert Mullen, MPH
Director, Evidence Based Practice in Communicative Disorders
American Speech-Language-Hearing Association

Karen Pace RN, BSN, MSN, PhD
Senior Program Director
National Quality Forum

Gregory Pawlson, M.D., M.P.H.
Executive Vice President
National Committee for Quality Assurance

Elizabeth Sandel, MD
Chief of Physical Medicine and Rehabilitation
Director of Research and Training
Kaiser Foundation Rehabilitation Center

Eric Tangalos, MD
Mayo Clinic

William E. Thar, MD, MPH
Chief Medical Officer
Complex Care
ParadigmHealth

John Votto, MD
Chief of Staff
Hospital for Special Care

Mary Ann Weiss, DNSc, RN
Associate Professor
Marquette University College of Nursing

The remainder of this section highlights the key discussion points from each of the sessions held during the second 2-day TEP meeting.

4.2.1 Cognitive, Emotional, Communication, and Other Group Items Session

During this session the cognitive workgroup presented the proposed items to the TEP and requested feedback regarding individual items. Initial responses from TEP members included concern over the time burden of this section, particularly with the self-report items that require patient interviews. Members indicated that the cognitive items are only relevant for a small percentage of the patient population and asking all patients presents a significant burden. Other TEP members indicated that clinicians may have some discomfort in asking these questions of their patients. Another critique of the cognitive items was the concern that there is little evidence supporting interventions that will lead to improved cognitive outcomes.

One TEP member reported on the use of the cognitive items during the first pilot test. A point raised was the importance of having a clinician who is familiar with the patient completing the cognitive items. For example, clinicians who are more familiar with a patient may be able to recognize if the patient is having a moment of lucidity though that may not be normal.

Brief Interview for Mental Status (BIMS.) TEP members discussed the need to include the BIMS in the assessment tool. While some members questioned if this set of items is necessary, others emphasized the importance of the BIMS for conducting a standard performance-based orientation and memory assessment. One concern that was raised related to the use of the BIMS was the potential for practice (i.e., repetition) effects given that the instrument will be administered at discharge from acute care and then at the time of admission and discharge from post-acute care. For example, a patient may be likely to remember the words "sock," "blue," and "bed," from the recall items from assessment to assessment.

Confusion Assessment Method (CAM). Discussion of the CAM included whether these items should be asked of all patients or only of patients with certain responses on the BIMS. The CAM is an important measure for identifying possible delirium; however, significant training is required to administer these items reliably. The amount of training required for reliability raised some concern among TEP members. Another concern was that it will take a long time to complete these items for patients with limited communication. One member recommended that CMS consider eliminating assessment of disorganized thinking. The TEP's final recommendation on the CAM was that it be explored further in the second pilot test.

Observational Assessment of Cognitive Function. The observational assessment items include: short- and long-term memory, memory/recall ability, and cognitive skills for daily decision making. TEP members recommended that the definition of short- versus long-term memory be clarified. Other members recommended that the short- and long-term memory items be eliminated since patients with dementia have memories.

Behavioral Symptoms. TEP members agreed that these data are important to capture and that they are easy to code even if an assessor spends only a brief time with a patient. The group recommended changing the title of the section to "Behavioral Signs or Symptoms."

Mood. Some TEP members raised concerns about the mood items. For example, "feeling down" may be difficult to ask in an acute setting given that a patient may be having a normal reaction to a new treatment or diagnosis. Other members asked if there would be an expectation of intervention based on the results of these items. If this is the case, then these items may lead to increased resource utilization. TEP members also raised concerns about whether clinicians would be ethically bound to act based on the items responses or whether the items would be used to determine if a patient was competent.

Pain. TEP members recommended that both the numeric rating scale and the verbal descriptor scale be included in the second pilot test to determine whether both were needed in the larger demonstration. The numeric rating is commonly used in most health care settings but the verbal descriptor scale was proposed as a better measure for cognitively impaired populations. The group also agreed that it is important to understand how pain affects function and how unrelieved pain limits daily activities since these differ by individual's pain tolerance levels which are the factor that will affect the extent to which treatment will be limited by pain.

4.2.2 Function Items Session

During this session the function workgroup presented the proposed items to the TEP and requested feedback regarding individual items. The function section included a set of core function items followed by a supplemental set of items depending on a patient's functional level where Level 1 is for bedfast patients, Level 2 is for patients with limited mobility/self-care skills, Level 3 is for patients with basic mobility, and Level 4 includes IADL measures for patients with higher function. TEP members recommended that there be an easy algorithm for clinicians to use to move between the core items and the Levels. The group liked the "mini-CAT" approach, but also suggested greater clarity in the rating scale levels and the use of assistive devices in assessment. In response to the function items presented, TEP members recommended that the section also include a measure for sit-to-stand, a measure of fall risk, stability and balance, and a self-report item for endurance such as shortness of breath. Given that a patient's functional status can change very quickly, TEP members stressed the importance of assessing these items within 24 hours of discharge.

Locomotion. The TEP agreed that the language on the locomotion items needs consistency and that rather than steps, the distances should be measured (including metric measures). Other members raised issues about the ability to measure the longer distance locomotion items in small apartment settings in the home health assessments. Walking on uneven surfaces was also raised as another locomotion item to include.

Instrumental Activities of Daily Living (IADLs). The TEP agreed that IADLs are important to capture because they are predictive of one-year death and disability in addition to being predictive of resource utilization and discharge destination. The group recommended that these items be asked in post-acute care settings only. Members indicated that managing oral medications and using a telephone are among the most critical IADLs. Other members indicated the importance of capturing transportation in this section.

Eating. The TEP discussed the definition of the eating item given that it includes both getting food to mouth and swallowing. Some members recommended that these items be

separated, but others pointed out that this definition is consistent with historical definitions of the eating item. An alternative is to keep the eating item as is, but also include a separate item to measure swallowing.

Weight-Bearing/Range of Motion. Members requested greater clarification for the directions for these items. Does the weight-bearing item include mandated or self-imposed limitations in weight-bearing? Is the range of motion item assessed as active or passive motion?

4.2.3 Medical Items Session

During this session the medical workgroup presented the proposed items to the TEP and requested feedback regarding individual items.

Primary Diagnosis/Comorbidities. A concern was raised that recording the ICD-9 for diagnosis was operationally challenging during the pilot test because this is not something that the nurses are necessarily familiar with. The group discussed the idea of a check-off list, but did not come to consensus on how it would be used. The TEP questioned if there would there be a link between the check-off list and what is actually coded on the claims. The TEP agreed that primary diagnosis should indicate the main reason that a patient is being treated, but there should also be a space to record other diagnoses.

Physiologic Factors. TEP members discussed the difference between critical lab values that the tool should capture versus lab values that are valuable, but not necessarily critical. Other lab values that the TEP recommended for inclusion were INR, HBA1c, and left ventricular ejection fracture. TEP members also recommended that "never tested" be changed to "not tested" and that the items distinguish between measured versus estimated height and weight.

Medications. TEP members questioned the purpose of the medications section. Many members indicated that the section requires too much for a tool that is not meant for care planning. They also indicated that if this section is meant to be a care planning tool, then it does not contain enough information. Understanding the treatment regimen is important for predicting resource utilization, but the items do not indicate how well a patient is managed. Other important medications issues include patient adherence, use of new medications, and other medication monitoring or management issues.

Pressure Ulcer/Wound. TEP members agreed that the location, length, and width of pressure ulcers is important to measure because it may limit what a clinician can and can't do. Other characteristics of pressure ulcers and wounds that the TEP recommended including were undermining and tunneling because these types of wounds cost more and their presence will determine discharge destination. The TEP recommended removing the items on healed pressure ulcers and agreed that distinguishing between stage 3 and stage 4 ulcers may be difficult. The group discussed including items assessing risk of pressure ulcer and Braden score was brought up as one measure that could be used. Other TEP members also recommended that these items include how long a patient has had a pressure ulcer.

Prognosis. Members of the panel agreed that this is a valuable item to include because it addresses palliative care needs. The group agreed that the "surprise" item might be useful to

include though there was discussion about who is qualified to answer this question. "Don't Know" was recommended as a response category for this item.

4.2.4 Social and Environmental Items Session

During this session the social and environmental workgroup presented the proposed items to the TEP and requested feedback regarding individual items.

TEP members discussed the caregiver items and experts in the OASIS development indicated that it may not matter who the help is, or whether the help is paid or unpaid. There has been a move to simplify the caregiver items to indicate if there is a willing caregiver available during the day, at night, or all the time. It is also important to note that the presence of a caregiver may be negatively related to functional status in some cases. Other caregiver issues include that the presence of a willing and able caregiver does not necessarily mean that the caregiver will have the proper knowledge or skills required to provide care. In other cases, willing and able caregivers get home and realize that they cannot manage all of the patient's needs. Other social and environmental issues related to caregiver availability include understanding the relationships that patients have with others in the community. Some beneficiaries may have extensive social networks of people who can assist them.

Other issues raised by the TEP included transportation and financial resources. Transportation availability differs significantly for beneficiaries in rural versus urban settings and is often dependent on the socioeconomic status of the community. Financial resources are particularly important in terms of understanding a beneficiary's ability to pay for medications as the inability to pay for medications may trigger readmissions.

4.3 Conclusions

The TEP input was extremely useful in raising issues across the different populations. Most representatives on both the clinical and research TEPs approached measurement in reference to their primary populations of interest. The TEP's composition lead to very broad and specific discussions about the types of issues that will need to be addressed in making the tool applicable to the entire range of patient populations.

In general, both TEPs agreed on the types of items that were important for measuring differences in patient need and outcomes. Much discussion focused on the language or coding options associated with different items but most agreed on the basic set of items needed to measure patient populations across settings. All recognized the importance of having standard measures that could collect differences in severity without encountering floor and ceiling effects. If possible, additional items would have been included to provide better measurement of specific populations. However, it was recognized that this uniform assessment effort needed to start at some point and could be modified in the future. The TEPs thought the modular approach of developing a standard item library that could be added to in the future was a useful model for minimizing burden, providing a range of standard measures, and improving the measures available for the future. The approach of building a dynamic instrument that could change with scientific advances was applauded.

SECTION 5
CARE TOOL PILOT TESTS

5.1 CARE Tool Pilot Tests

Two pilot tests were conducted during the early development of the CARE tool. The alpha test, Pilot 1, examined the feasibility of data collection by the two types of providers that do not currently collect patient assessment data: acute hospitals and long-term care hospitals (LTCHs). The purpose of the beta test, Pilot 2, was to examine feasibility of the CARE tool in four post-acute care settings and acute care hospitals. This section describes the settings of the pilot tests, the results of analysis of CARE tool measurement attributes, and the item response rates.

5.1.1 Summary of Key Findings

All items in the CARE tool demonstrated their ability to garner responses in all settings. In four of the seven domains, most settings had item response rates of at least 80 percent. Core items, which were addressed to all patients administered the survey, had the highest response rates. Items calling for open lists, such as diagnosis, medications, and procedures, were thoroughly filled out, in some cases using all available space.

Rates of response to skip-logic questions were lower than for items without screening questions or special instructions. Contradictions were found in respondent's answers to screening and subsequent items. Most items which were to have been answered only by screened respondents were answered by both screened and unscreened respondents. Attention to the flow of items, formatting, and instructions may be necessary to improve response rates for the desired respondents, and eliminate responses by those to whom questions do not pertain.

We conclude that the CARE rating scales steps are working effectively to describe different levels of patient function. Only one element of the functional status domain, tube feeding, was found to be fundamentally different than other patient function items. The patient scales for Self-care+IADL and mobility did not display substantial subdimensions to these scales when tested, but further data collection on a larger range of patients is needed before determining the final structure of the mobility scale. Even though some facilities had difficulty selecting the appropriate level of supplemental items for patients, resulting in less than full identification of their functional status, the functional scales demonstrate construct validity and the constructs are stable across patients.

5.1.2 Pilot 1

Three facilities in the Chicago area were involved in data collection for Pilot 1: two acute care hospitals (Alexian Brothers Medical Center and Edward Hospital) and one long-term care hospital (RML Hospital). These three facilities also participated in Pilot 2 and are described in detail in that section. Data were collected in a paper and pencil format for 7 days on all patients admitted or discharged during that time. A 4-hour training session was conducted at each facility (April 9 and 10, 2007), and data collection began the day following the training session. Help desk support was provided by staff at the Center for Rehabilitation Outcomes at the Rehabilitation Institute of Chicago.

At the end of the data collection period a total of 74 assessments were completed: 29 acute discharge assessments at Alexian, 15 acute care discharge assessments at Edward, and 30 PAC assessments at RML.

Following the data collection period, in-person interviews of the data collectors at RML Specialty Hospital and Edward Hospital were performed, and a telephone interview was conducted with the coordinator at ABMC. Data collection challenges identified by the acute care hospitals included easy identification of Medicare fee-for-service patients, identifying the anticipated discharge date and discharge delays. These later concerns were challenging because a number of items draw on observations made during the last 2 days of the patient's stay. Participants found that the instructions on the forms were generally clear, but suggestions for improving instructions, including skip patterns, were provided. Information collected at these interviews contributed to revision of the CARE instrument for the Pilot 2 data collection.

5.1.3 Pilot 2

Nine facilities were involved in data collection for Pilot 2: three acute care hospitals, two inpatient rehabilitation facilities (one unit, one freestanding), one skilled nursing facility (freestanding), three long-term care hospitals (three freestanding), and two home health agencies (one hospital-based, one freestanding). Pilot 2 analyses included 581 records; 102 acute hospital discharge records, 300 PAC admission records, and 179 PAC discharge records. The numbers of records in each setting, for each type of assessment, are displayed in ***Table 5-1.***

Table 5-1
Distribution of pilot study records by setting and type of assessment

Setting assessment	Number of records	Percent of pilot records
Acute Hospital Discharge	102	18
LTCH Admission	122	21
LTCH Discharge	65	11
IRF Admission	103	18
IRF Discharge	100	18
SNF Admission	45	8
SNF Discharge	5	1
HHA Admission	30	5
HHA Discharge	9	2

Training was provided using a train-the-trainer model. We provided three 6-hour training sessions on June 21, 29, and 30. Following the train-the-trainer session we visited each hospital to assist the new trainers to train their colleagues. Help desk support was provided by the staff at the Center for Rehabilitation Outcomes Research at the Rehabilitation Institute of Chicago. While data may have been collected on paper forms on the clinical floor, data for this pilot test were submitted through a web-based data entry system.

5.1.4 Acute Care Hospitals

The three participating acute care hospitals were: Alexian Brothers Medical Center, Edward Hospital, and Rush-Copley Medical Center.

Alexian Brothers Medical Center. Alexian Brothers Medical Center is located in west suburban Elk Grove Village. It is a 387-bed nonprofit, church-based system. Alexian Brothers Medical Center provides short-stay acute care, inpatient rehabilitation, inpatient behavioral health, and home health care services. Approximately 50 percent of its patients are Medicare recipients. Data were collected on the orthopedic unit, the medical unit, and the inpatient rehabilitation unit. Data collectors included physical therapists, respiratory therapists, and the manager of quality improvement. A total of 39 acute care discharge assessments were completed. Data collection in the 66-bed inpatient rehabilitation unit was performed by occupational and physical therapy for chart review information and nursing for interview items. A total of 51 admission assessments and 55 discharge assessments have been completed

Edward Hospital. Edward Hospital is located in southwest suburb of Naperville. It is a 236-bed community hospital. It provides short-stay acute care and home health care services. Approximately 35 percent of its patients are Medicare recipients. Inpatient units participating in data collection included the orthopedic/surgical unit and the cardiac telemetry unit. The home health care department was also involved in data collection. Data collectors included registered nurses and occupational and physical therapists. A total of 16 discharge assessments from the acute care units have been completed as well as 8 admission and 8 discharge assessments from the home health care unit.

Rush-Copley Medical Center. Rush-Copley Medical Center is located in southwest suburban Aurora. It is a 183-bed facility with five Centers of Excellence in the provision of cancer care, cardiovascular services, emergency services, women's health, and neuroscience. About 28 percent of its patients are Medicare beneficiaries. Inpatient units participating in data collection include: medical-surgical, Cancer Care, and Intermediate Care Unit (medical, cardiology, neurology). Data on function and cognition were collected by an occupational therapist, while the rest of the items were collected by nursing. As of June 26, 2007, 15 acute care discharge assessments have been completed.

5.1.5 Inpatient Rehabilitation Facilities (IRFs)

One freestanding inpatient rehabilitation facility, Marianjoy Rehabilitation Hospital, participated in data collection.

Marianjoy Rehabilitation Hospital. Marianjoy Rehabilitation Hospital is a 116-bed church-based facility located in the western suburb of Wheaton. Approximately 65 percent of patients served are Medicare beneficiaries. Admissions throughout the facility were included in data collection. Data were collected by nursing, physical therapy, and occupational therapy. A total of 52 admission assessments and 45 discharge assessments were completed.

As noted above, the IRF unit at Alexian Brothers Medical Center also participated in Pilot 2 data collection efforts.

5.1.6 Skilled Nursing Facility (SNF)

Manor Care at South Holland. Manor Care at South Holland is a 160-bed for-profit skilled nursing facility located in the southern suburbs. A majority of their patients are Medicare recipients. Admissions from throughout the facility were included in data collection. Data on administrative and functional items were collected by nursing (MDS nurses) and social work collected data on administrative and cognitive items. A total of 45 admission assessments were completed and 5 discharges were completed.

5.1.7 Long-Term Care Hospitals

Three long-term care hospitals participated in data collection. They include RML Specialty Hospital, Kindred HealthCare Central, and Kindred HealthCare Sycamore.

RML Specialty Hospital. RML Specialty Hospital is a 90-bed University-owned, long-term care facility located in the south west suburb of Hinsdale. They are nationally recognized as a center of excellence for ventilator weaning, wound management, and medically complex patients. Approximately 60 percent of their patients are Medicare recipients. Admissions throughout the hospital were included in data collection. Nursing, Quality Manager, Respiratory Therapy, and Psychology staff collected the data. Psychology staff primarily performed the cognitive interview. The other disciplines collected data on all items. A total of 43 admission assessments and 27 discharge assessments were completed.

Kindred HealthCare Central. Kindred HealthCare Central is a 190-bed for-profit, long-term care hospital located on the north side of the city of Chicago. About 73 percent of their patients are Medicare recipients. Admissions throughout the institution were included in data collection. Nursing staff were involved in data collection. A total of 42 admission and 7 discharge assessments have been completed.

Kindred HealthCare Sycamore. Kindred HealthCare Sycamore is a 69-bed for-profit, long-term care hospital located in a rural community 70 miles west of the city of Chicago. Approximately 61 percent of their patients are Medicare beneficiaries. Admissions throughout the facility were included in data collection. Nursing and respiratory/laboratory manager were involved in data collection with support from physical and occupational therapists. A total of 42 admission assessments and 7 discharge assessments have been completed.

5.1.8 Home Health Care Agencies (HHAs)

VNA Fox Valley. VNA Fox Valley is a nonprofit home health care agency located in the southwest suburb of Aurora. They specialize in home IV infusion therapy, wound care, mother/baby/pediatric care, mental and behavioral health care, palliative care, and rehabilitative therapies. Nursing staff collected all of the data. A total of 22 admission assessments and 1 discharge assessments were completed.

As noted above, Edward Hospital's home health care unit also participated in data collection.

Help desk support provided during the Pilot 2 test included questions about whether data could be left blank if not available (e.g., education level), coding of functional assessment levels, inclusion of patients on Part B Medicare only and Medicaid patients. Most help desk questions were related to data entry issues, such as web pages not advancing, "unchecking" items that had been checked by mistake, and screen resolution issues.

Data collectors from each facility were invited to attend one of two debriefing sessions. During these sessions, data collectors were asked to describe challenges in the collection of data and how these obstacles were overcome. One area of feedback focused on the use of "levels" for the functional assessment items. Items had been grouped into levels, and clinicians were asked to select the best level for the patients. This clinicians found this task challenging.

Two web-based data entry de-briefing calls were also held. Clinicians provided feedback regarding data entry concerns as well as preferences for the system under development.

The Pilot 2 analyses reviewed 581 records. The numbers of records in each PAC site, for each type of assessment, are displayed in ***Table 5-2***. LTCHs and IRFs have the largest proportions of records, followed by HHAs, and the SNF.

Table 5-2
Number of records per case: PAC facilities

Site	Type of setting	Cases with an admission and discharge record	Cases with one record (admission or discharge record)
Kindred Central	LTCH	11	46
Kindred Sycamore	LTCH	1	35
RML Specialty Hospital	LTCH	27	15
Alexian Brothers Medical Center	IRF	50	6
Marianjoy Rehabilitation Hospital	IRF	45	2
Manorcare	SNF	2	44
Total	**—**	**136**	**148**

Assessments were completed by PAC staff on 284 cases. Among those, 148 cases had only admission records or only discharge records, and 136 cases had both admission and discharge forms for the same patient (two records). Because Pilot 2 was implemented for two months, IRFs with shorter lengths of stay were able to generate the largest number of cases with two records. The skilled nursing facility and long-term care hospitals and home health agencies had few cases with two records, with the exception of RML Specialty Hospital, a LTCH.

The Acute Hospitals completed only discharge assessments. Alexian Brothers Medical Center AH Discharge had 39 cases, Edward Hospital AH Discharge had 16 cases, and Rush Copley Medical Center Discharge had 47 cases.

5.2 Item Response Rates: Response Patterns by Setting

The CARE tool was designed to be applicable to all new admissions and discharges, but to maximize efficiency and relevance, items were divided into core items (answered by all) and supplemental items which provided greater detail for patients having a condition. Screening questions were provided to guide whether subsequent items should be completed for any given patient. Such questions are noted and analyzed separately.

For simplicity, the Acute Hospital Discharge (AHD) instrument is used as an outline of instrument sections and items numbers. For the analysis, each item was assigned a variable name corresponding to its item number on the AHD instrument. The tables in this section use that numbering.

The data collection sites and individual patient records were identified for this study by using a Case ID number—a unique number assigned to each patient within a unique range for each site. This item was completed for all patients, but did not represent an "official" item of the CARE Instrument. The Case ID number ensured that all records could be identified while protecting patient confidentiality.

The focus of this analysis is the utility of the instrument to collect patient information; therefore, the analysis describes systematic response or nonresponse to questions about patients. Questions that applied only to respondents targeted via the use of a screening question—called skip-logic questions—are displayed in ***Appendix D***. ***Appendix E*** shows responses to multiple-choice and check all that apply questions. These responses were analyzed for the same purpose: to see if there was a consistent pattern of nonselection among choices.

Certain response patterns emerged across settings, but more often responses varied more between data collection sites than between types of settings. There were only 5 SNF discharge assessments, so they are not reported in the tables below. LTCHs produced more than 27 percent of the records, but their discharge response rates were generally the lowest. This is not of concern, however, because early in the pilot it was determined that this was occurring, and was due to timing constraints rather than staff ability and willingness to participate.

5.2.1 Domain I—Administrative Items

The administrative items include identifying, demographic, and legal information, as shown on ***Table 5-3***. The response rate for demographic items varied by type of question and

was somewhat lower in LTCHs than other settings. Discharge assessments with more than 10 percent missing were from sites with fewer than 10 such records. The education level item was missing more than four times as often as the other items. This information is not routinely collected by many sites. IRFs and the SNF were most able to respond to this item, 78 percent of patients. HHAs were missing up to 25 percent of responses, AHs up to 38 percent of responses, and LTCHs up to 100 percent. Among PACs, education level was completed on admission assessments more often than discharge assessments.

Table 5-3
I. Administrative items: Percent missing responses by setting

Item	Item Name	AH (frequency 102) percent missing responses	LTCH (frequency 187) percent missing responses	IRF (frequency 203) percent missing responses	SNF (frequency 50) percent missing responses	HHA (frequency 39) percent missing responses
	Provider Information					
IA1A	A1. Provider Name	2	2	0	2	0
IA1B	A2. Provider Number	0	19	3	4	1
IA6	A6. Birth Date	8	1	0	60	8
IA8	A8. Gender	0	9	3	8	3
IA9	A9. Race/Ethnicity	2	8	5	10	3
IA10	A10. Education Level	22	78	7	12	62
IA11	A11. Advance Directive	5	18	5	12	5
IA12	A12. Power of Attorney	2	18	4	12	8
IA13	A13. Code Status	6	10	4	20	5
	Payer Information					
IB1	B1. Payment Source	2	4	2	4	0
Domain I	Average % Missing	5	17	3	14	10

A few multiple choice options were not used. For Race/Ethnicity, "American Indian or Alaska Native" was not selected. For payer information, the following were not selected: Workers' Compensation, Title programs, other government, and unknown. Medicaid HMO was selected for only one patient, and Medicare HMO was selected for only three patients.

In general, administrative items were successfully collected by each setting. Level of education had higher percent missing in all settings than all other administrative items. The unused selections for race/ethnic and payer items are likely to be related to region and underlying population and not a function of the items themselves.

5.2.2 Domain II—Admission Information

Admission information consists of two subdomains: descriptive information about the admission, and social and functional items about the patient prior to the current episode of care. These items were asked on both PAC admission and acute hospital discharge assessments, but not on PAC discharge assessments.

The date and source of admission were consistently reported, except in one setting. The source of admission was consistently completed. The answer choice "psychiatric hospital or unit" was not used.

The primary diagnosis at admission was missing in at least 25 percent of records in each setting except SNF. This item was completed when the patient was admitted from an institutional setting that had provided a diagnosis. This consistently high percent missing contrasts with the primary diagnosis item, in Domain III, which was missing in few cases. The item about other services was intended to be answered only for patients who had received services in addition to those available at their previous setting, so it did not apply to all patients. The result is included in ***Table 5-4*** to demonstrate that it was possible to complete it in all settings.

Table 5-4
II. Admission information: Percent missing responses by setting

Item	Item Name	AH (frequency 102) percent missing responses	LTCH (frequency 122) percent missing responses	IRF (frequency 103) percent missing responses	SNF (frequency 45) percent missing responses	HHA (frequency 30) percent missing responses
IIA1	A1. Adm Date	8	32	6	2	7
IIA2	A2. Adm From	4	33	8	2	3
IIA3A	A3a. Primary Diagnosis	86	49	50	2	37
IIA3B	A3b. ICD-9CM	100	91	55	80	80
IIA4	A4. Other Services	83	69	80	64	87
	Patient Information Prior					
IIA5	A5. Prior Residence	5	36	9	9	7
IIA6	A6. Zip Code	19	48	7	2	27
IIA7	A7. Prior Lives With	19	54	10	9	7
IIA8A	A8a. Self-Care	6	34	17	0	3
IIA8B	A8b. Mobility	7	35	16	0	3
IIA8C	A8c. Functional Cognition	9	36	15	0	3
IIA9	A9. Prior Mental Status	8	34	16	2	3
IIA10	A10. Incontinence	7	34	11	0	3
Domain II	Average % Missing	28	49	28	19	26

NOTE: Domain II items appeared only in PAC admission forms, not PAC discharge forms.

The response rates for patient information prior to this episode varied by item and setting. Very few records had missing items in the IRF, SNF, and HHA. The most difficult items appeared to be zip code and identifying who the patient lived with before admission. Zip code was high in AHs, LTCHs, and HHAs.

The date of admission was well completed, but was not included in the PAC discharge version of the CARE tool. Admission information was generally well completed except for three items: Primary Diagnosis, Zip Code, and Prior Lives With.

5.2.3 Domain III—Current Medical Items

This section of the instrument contains current medical information. Subsections differ on the following:

- Which of the AH Discharge, PAC Admission, or PAC Discharge instruments contain them
- Whether items should be completed for all patients or only patients to whom they apply
- Whether there is a screening question determining whether a subsequent item should be answered

For Pilot 2, sites were asked to provide written descriptors for diagnosis but were not required to provide corresponding ICD-9 CM codes.

The first subsection, *Primary Diagnosis*, applied to all patients. As noted earlier, this field was completed for nearly all assessments in all settings. The next subsection, *Other Diagnosis, Complications*, provides fields for entering up to 15 additional diagnoses or complications. After the eighth diagnosis, fewer than 20 percent of respondents had further diagnoses. However, 30 records, primarily at IRFs, had 15 other diagnoses listed. It is possible that had more space been provided, additional diagnoses would have been listed.

Because they could only be identified during the course of the patient's stay, the *Procedures* subsection was limited to Discharge forms. This subsection began with a screening question for all respondents, "Did the patient have one or more diagnostic or therapeutic procedures?" In three of the settings, 18 percent of assessments were missing responses to this question. ***Table 5-5*** presents the response rates to the screening question and the first procedure listing item.

The screening question was answered on 82 percent of discharge assessments (231 responses out of 281 records), with 56 percent replying "yes" the patient had received a procedure. The majority of these cases were in hospitals (acute, LTCH, and IRF). Among those patients screened as having had a procedure (the "yes" respondents), 73 percent were documented as having received at least one procedure. Among respondents who either skipped the screening question or replied "no" to the screening question, 19 percent (23 respondents) subsequently reported at least one procedure.

Table 5-5
Skip logic of procedures: Screening and first procedure items by setting

Question	Skip Logic	Result	AH Discharge (n=102)	LTCH Discharge (n=65)	IRF Discharge (n=100)	SNF Discharge (n=5)	HHA Discharge (n=9)	Overall (n=281)
IIIC1. Did the patient have one or more diagnostic or therapeutic procedures during this admission?	One or More Procedures with "Yes" Responses	"Yes" Responses	72	16	54	0	0	142
—	—	Total Responses	84	32	82	2	2	202
—	—	% missing	18%	18%	9%	60%	77%	—
—	—	% "Yes" Responses	86%	51%	18%	0%	0%	70%
IIIC1a. Procedure	Percent missing of those Responding Yes to IIIC1 (One+ Procedures)	Expected Responses	71	9	26	—	—	106
—	—	Total Responses	86	13	26	1	1	127
—	—	% missing	1%	44%	52%	—	—	—

The *Treatments* subsection was included on all assessment forms, and the first possible choice was no treatments. HHAs had 23 responses to the "no treatments" option, and 1 treatment (insulin drop) option. Fifteen HHA records did not report either the "no treatments" option or select any treatment, indicating that the subdomain was not completed. AHs, LTCHs, and IRFs reported many possible responses to the treatment question. Three responses were never selected:

1. Peritoneal dialysis
2. Halo
3. Complex external fixators

Space was provided for up to 30 *Medications* to be listed, although sites were free to submit medication lists from within their electronic medical record as an alternative. Because this item is primarily a "transitions" item, this subsection is included only in discharge assessments. For each medication, the name, dose, route, and frequency, were to be reported. The planned stop date was to be reported as appropriate and was rarely recorded on the form (fewer than 20 occurrences). This item was only appropriately completed for short-term medications, as medications for chronic conditions generally do not have a planned stop date. The HHAs and SNF reported the dose, route, and frequency for each medication on the discharge form. AHs reported dose and frequency for 80 to 90 percent of medications, but reported route for less than 25 percent of medications. The names of medications were well reported, and some respondents appeared willing to write out up to 30. Route, dose, and

frequency were difficult to obtain from sites writing medications into the form. Some sites were able to print out medication lists from their electronic medical records. These contained medication name, dose, frequency, and route.

Most patients took only one medication (70 percent), while only 10 percent of patients were reported as taking 20 medications. Reflecting the greater medical severity of patients, AHs, LTCHs, and IRFs reported approximately 20 percent of their patients taking 20 medications. There were 14 patients reported as taking 30 medications. Among records for which a medication list from an electronic medical record was attached, four patients had 34 medications, and two had 41 medications—more than the maximum of 30 that could be recorded on the pilot version of the CARE tool.

The maximum number of medications by type of institution is shown in ***Table 5-6***.

Table 5-6
Maximum numbers of medications per patient

Setting	Number of medications
AH	30
LTCH	34
IRF	41
HHA	27

NOTE: The SNF had too few discharges to be included in this analysis.

The *Allergies* subsection of Current Medical Items followed the same structure as the *Procedures* subsection and was also asked only on discharge assessments. First a screening question asked whether the patient has known allergies or drug reactions, followed by space to record 16 separate allergies or drug reactions. The screening question was not answered in 21 to 26 percent of AH, LTCH, and IRF assessments, and in 56 percent of HHA assessments. Only 2 patients in all sites had more than 7 allergies reported. The five SNF discharge assessments are not included in this analysis.

In the *Pressure Ulcers* subsection, all respondents should have completed the first two questions on risk assessment and presence, and most did. Aside from LTCHs, fewer than 20 percent of assessments were missing responses to these questions. The remaining items were only completed by those reporting the presence of at least one pressure ulcer. The response pattern to these questions is in ***Table 5-7***. Pressure ulcers occurred primarily in the three PAC settings with the highest acuity.

Table 5-7 shows the screening questions, with the number and percent of respondents who responded "yes" to the screening question. Following the screening question is the response rates for the item answered by those "passing" the screener. The screener question did not always work as intended as the following example demonstrates.

Table 5-7
Response rates to pressure ulcer questions

Item Name	Skip logic	Result	AH disch	LTCH admit	LTCH disch	IRF admit	IRF disch	SNF admit	SNF disch	HHA admit	HHA disch	Overall	Percent of total responses screened
IIIG1b. Unhealed Pressure Ulcers Present	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	2	36	20	13	9	6	1	1	—	88	—
—	—	Total Responses	5	67	41	20	18	24	1	2	1	179	49%
—	—	% missing	33	16	17	13	18	0	0	50	—	—	—
IIIG2a.	# of Unhealed Stage 2 Ulcers. Responding Yes to IIIG1B and > 0 to IIIG2A	Responses > 0	2	36	20	13	9	6	1	1	—	88	—
—	—	"Yes" Responses	3	43	24	15	11	6	1	2	—	105	—
—	—	% Responses > 0	67	84	83	87	82	100	100	50	—	84	—
IIIG2b. Number of Pressure Ulcers Discovered During This Admission	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	0	18	0	8	0	0	0	—	29	—
—	—	Total Responses	4	0	38	0	17	0	0	0	1	60	48%
—	—	% missing	0	100	25	100	27	100	100	100	—	—	—
IIIG2c. Unhealed Pressure Ulcers Present	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	2	34	17	8	5	6	1	2	—	75	—
—	—	Total Responses	2	65	37	15	11	24	1	3	0	158	47%
—	—	% missing	33	21	29	47	55	0	0	0	—	—	—
IIIG2c.	# of Unhealed Stage 3 or 4 Ulcers. Responding Yes to IIIG1B and > 0 to IIIG2C or IIIG2E	Responses > 0	2	38	20	8	5	6	1	2	—	82	—
—	—	"Yes" Responses	3	43	24	15	11	6	1	2	—	105	—
—	—	% Responses > 0	67	88	83	53	45	100	100	100	—	78	—

(continued)

Table 5-7 (continued)
Response rates to pressure ulcer questions

Item Name	Skip logic	Result	AH disch	LTCH admit	LTCH disch	IRF admit	IRF disch	SNF admit	SNF disch	HHA admit	HHA disch	Overall	Percent of total responses screened
IIIG2d. Number of Pressure Ulcers Discovered During This Admission	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	0	14	0	4	0	0	0	—	21	—
—	—	Total Responses	3	0	33	0	10	0	0	0	0	46	46%
—	—	% missing	0	100	42	100	64	100	100	100	—	—	—
IIIG2e. Unhealed Pressure Ulcers Present	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	2	37	18	6	3	6	1	2	—	75	—
—	—	Total Responses	2	68	38	13	9	24	1	3	0	158	47%
—	—	% missing	33	14	25	60	73	0	0	0	—	—	—
IIIG2e.	# of Unhealed Stage 3 or 4 Ulcers. Responding Yes to IIIG1B and > 0 to IIIG2C or IIIG2E	Responses > 0	2	38	20	8	5	6	1	2	—	82	—
—	—	"Yes" Responses	3	43	24	15	11	6	1	2	—	105	—
—	—	% Responses > 0	67	88	83	53	45	100	100	100	—	78	—
IIIG2f. Number of Pressure Ulcers Discovered During This Admission	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	0	16	0	3	0	0	0	—	22	—
—	—	Total Responses	3	0	35	0	9	0	0	0	0	47	47%
—	—	% missing	0	100	33	100	73	100	100	100	—	—	—
IIIG2g. Unhealed Pressure Ulcers Present	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	38	15	8	4	6	1	2	—	77	—
—	—	Total Responses	3	68	36	15	10	24	1	3	0	160	48%
—	—	% missing	0	12	38	47	64	0	0	0	—	—	—

(continued)

Table 5-7 (continued)
Response rates to pressure ulcer questions

Item Name	Skip logic	Result	AH disch	LTCH admit	LTCH disch	IRF admit	IRF disch	SNF admit	SNF disch	HHA admit	HHA disch	Overall	Percent of total responses screened
G2h. Number of Pressure Ulcers Discovered During This Admission	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	0	14	0	4	0	0	0	—	21	—
—	—	Total Responses	3	0	34	0	9	0	0	0	0	46	46%
—	—	% missing	0	100	42	100	64	100	100	100	—	—	—
IIIG3. Number of unhealed	Percent missing of those Responding > 0 to IIIG2A (Number of Unhealed Stage 2)	Expected Responses	2	44	31	12	8	21	1	1	1	121	—
—	—	Total Responses	3	53	35	16	10	21	1	3	1	143	85%
—	—	% missing	60	34	24	40	56	13	0	50	0	—	—
D4. Longest													
IIIG4a. Enter Length in cm	Percent missing of those Responding > 0 to IIIG2C or IIIG2E (Number of Unhealed Stage 3 or 4)	Expected Responses	0	47	26	4	2	8	1	0	—	0	76%
—	—	Total Responses	2	61	38	4	2	8	1	0	0	88	—
—	—	% missing	100	32	35	73	82	67	0	100	—	—	—
IIIG4b. Enter Width in cm	Percent missing of those Responding > 0 to IIIG2C or IIIG2E (Number of Unhealed Stage 3 or 4)	Expected Responses	0	47	26	4	2	1	0	—	—	80	74%
—	—	Total Responses	2	61	38	4	2	1	0	0	—	108	—
—	—	% missing	100	32	35	73	82	0	100	—	—	—	—
IIIG5. Presence of Tunneling	Percent missing of those Responding > 0 to IIIG2C or IIIG2E (Number of Unhealed Stage 3 or 4)	Expected Responses	0	60	33	10	4	17	1	1	—	126	—
—	—	Total Responses	2	67	37	15	15	17	1	2	0	156	81%
—	—	% missing	100	13	18	33	64	29	0	67	—	—	—

For LTCH admission assessments, 43 records indicated a pressure ulcer was present in the screener question. However, only 36 of the 43 screener respondents completed the next item, QIIIG2A, "Number of Unhealed Pressure Ulcers." Yet there were 67 total responses to item suggesting a number of respondents completed this item without completing the screener question.

At discharge, respondents were asked to indicate if any unhealed pressure ulcers had been discovered during this admission at each stage (or were found but were unstageable). "None" was among the choices for response. The response rate for discovery during this admission was examined for those who indicated a positive number of unhealed pressure ulcers of a given stage. The "discovery" response was missing for approximately 25 percent of screened cases, and was answered by approximately twice as many respondents who did not respond positively on the screening item. Respondents who recorded answers for one of the four questions about number of ulcers at each stage usually answered all of them plus the "discovered during this admission" item.

The items reporting length and width of the longest stage 3 or 4 pressure ulcer were recorded for 70 percent of patients screened to be appropriate for the item, and for an additional 28 patients not noted as having a pressure ulcer on the screening item. The presence of tunneling item had few responses from unexpected respondents. Among those who did screen to answer the item, the response rate was best in the settings with the highest number of patients with pressure ulcers.

The *Major Wound* subsection had an introductory screening question regarding the presence or absence of wounds, applicable to all respondents on all assessment types. The SNF had the lowest percent missing: 20 percent. IRFs were missing an average of 46 percent of responses, the largest of any setting. The major wounds items may have been missed because of the skip logic of the preceding pressure ulcer items, or because of their placement on the page. The between-site variation, however, was large.

The response rate for *Turning Surfaces* was lower than that for "unhealed pressure ulcers present," indicating that not all respondents who should have completed this question did so. As with the Major Wound subsection, the item may have been overlooked because of its placement, the order of items, and skip pattern instructions.

Physiologic Factors report clinical test results. This subsection appeared on all assessments forms. Response rates are shown on ***Table 5-8***. Many of the items in this subsection may not have been clinically necessary for some patients; respondents were instructed to indicate "NT" for a test not taken. Because of the large number of items in this section, responders may have skipped the entry, rather than writing in "NT." The number of "NTs" varied by clinical test more than by type of assessment. Each test completed was to have the date assessed and result entered. For most tests, in most sites, this was done. In two of the settings, for one type of assessment, the date was completed more often than the test result.

Table 5-8
Physiologic values items: Percent of responses missing or not taken

III. Current medical items	AH disch	LTCH admit	LTCH disch	IRF admit	IRF disch	SNF admit	SNF disch[1]	HHA admit	HHA disch[2]
H1b. Enter Height in Inches	68	32	63	50	52	36	20	60	22
H2b. Enter Height in Centimeters	47	70	86	57	51	100*	100*	100*	100*
H3b. Enter Weight in Pounds	71	48	48	55	82	38	20	60	33
H4b. Enter Weight in Kilograms	36	48	68	10	4	76	100*	100*	89*
H5b. Enter Temperature in Degrees Fahrenheit	7	16	6	7	3	4	20	23	11
H6b. Enter Temperature in Degrees Celsius	98*	86	91*	100*	100*	100*	100*	100*	100*
H7b. Enter Heart Rate in Beats per Minute	7	15	8	7	3	4	20	17	11
H8b. Enter Respiratory Rate Breaths per Minute	9	20	8	7	4	4	20	17	11
H9b. Enter Blood Pressure Value	8	15	6	7	3	4	20	23	11
H10b. Enter O2 saturation (Pulse Oximetry) Value	8	48	49	45	38	89	60	53	78
H11b. Enter Hemoglobin (gm/dL)	7	17	6	9	3	84	100*	100*	100*
H12b. Enter Hematocrit (%)	6	17	6	9	3	84	100*	100*	89*
H13b. Enter WBC (K/mm3) Value	8	16	6	10	5	84	100*	100*	89*
H14b. Enter HgA1c (%) Value	93	99*		99*	98*	98*	100*	100*	100*
H15b. Enter Sodium (mEq/L) Value	11	19	6	15	9	84	100*	100*	89*
H16b. Enter Potassium (mEq/L) Value	11	19	5	16	8	84	100*	100*	89*
H17b. Enter BUN (mg/dL) Value	10	18	5	15	8	84	100*	100*	89*
H18b. Enter Creatinine (mg/dL) Value	10	17	8	15	11	84	100*	100*	89*
H19b. Enter Albumin (gm/dL) Value	48	27	37	37	48	87	100*	100*	100*
H20b. Enter Prealbumin Value	100*	99*	92	100*	100*	100*	100*	100*	100*
H21b. Enter INR Value	35	46	60	53	48	84	40	100*	89*
H22b. Enter pH Value	82	66	77	100*	99*	100*	100*	100*	100*
H23b. Enter PaCO2 Value	82	66	77	100*	100*	100*	100*	100*	100*
H24b. Enter HCO3 Value	82	67	77	100*	100	100*	100*	100*	100*
H25b. Enter PaO2 Value	85	66	77	100*	100*	100*	100*	100*	100*
H26b. Enter SaO2 Value	90	65	75	100*	100*	100*	100*	100*	100*
H27b. Enter B.E. (base excess) Value	85	68	78	100*	100*	100*	100*	100*	100*
H28b. Enter Left Ventricular Ejection fraction (%) Value	86	97*	100*	100*	100*	89	60	100*	100*

*Indicates tests for which there were less than three responses or no values for a specific setting assessment.

[1,2] There were five SNF and nine discharge assessments collected during the pilot test.

Sites with more clinically involved patients—AHs, LTCHs, and IRFs—reported more physiologic tests than the SNF and the HHAs. The response rate for sites within settings varied. Tests for which no values were recorded are shown in grey in ***Table 5-8***. The tests for which there were less than three responses for a specific setting assessment are also shaded. Three tests did not have values reported in any setting, or only in AH setting:

1. HgA1c (%) Value
2. Pre-albumin Value
3. Left Ventricular Ejection Fraction (%) Value

Some tests were completed only in AHs and LTCHs reflecting the types of patients treated in those settings. Those tests were as follows:

1. Temperature in Degrees Celsius
2. pH Value
3. PaCO2 Value
4. HCO3 Value
5. PaO2 Value
6. SaO2 Value
7. B.E. (base excess) Value

HHAs had values for only 8 of the 28 physiologic tests, as shown on ***Table 5-8***. The shaded cells had no responses or fewer than four responses.

Height, weight, and temperature measures were recorded in standard or metric units. As seen in ***Table 5-8***, the response rate was greater in standard measures than in metric measures. In many cases, values were recorded in both standard and metric units. ***Table 5-9***, below, describes the percent of completed responses that reported metric units only. This occurred primarily in acute hospitals, and also in LTCHs and IRFs. The SNF and HHAs used standard units. Temperature was completed in Fahrenheit in all but one case.

There were some records in which height, weight, and temperature were not reported at all. As might be anticipated, height is not routinely collected in home health settings, 60 percent of records were missing this item. This item was missing for 35 percent of records from the SNF; the range of missing heights in more intensive settings ranged from 3 percent of IRF discharges to 31 percent of LTCH discharges. The pattern for missing weights was similar. Probably reflecting the greater frequency with which temperature is collected in health care settings, this item was missing infrequently in all settings. Overall, fewer than 10 percent of cases were missing temperature.

Table 5-9
Percent of metric plus standard responses entered solely in metric values

Item	AH disch	LTCH admit	LTCH disch	IRF admit	IRF disch	SNF admit	SNF disch	HHA admit	HHA disch
H2b. Enter Height in Centimeters[1]	62	18	23	46	51	0	0	0	0
H4b. Enter Weight in Kilograms[2]	68	39	29	52	81	0	0	0	14
H6b. Enter Temperature in Degrees Celsius[3]	1	0	0	0	0	0	0	0	0

[1] Seven sites had at least one assessment with height in Centimeters only.

[2] Six sites had at least one assessment with weight in Kilograms only.

[3] One site had one assessment with temperature recorded in Celsius only.

In summary, the Current Medical Items domain contained several open-ended lists: secondary diagnoses, diagnostic or therapeutic procedures, medications, and allergies. All available spaces for the lists were used in at least one setting. Response rates to these items were generally above 80 percent. The treatment subdomain included an option for "none." "None" was not consistently used properly—the item was skipped, or "none" was checked as well as other treatments. The response rate for pressure ulcer risk assessment and screening question for presence had high response rates, generally above 80 percent in each setting. The initial and secondary screening questions in the Pressure Ulcers subdomain were also used incorrectly. As with treatments, the screening question was sometimes skipped rather than answered with "no" or "zero," and respondents who did either skip or reply negatively to the screening question went on to answer items they should have been screened away from answering. In the Physiologic Factors subdomain, three tests were used only in AH settings. Temperature was not reported in Celsius without also being reported in Fahrenheit except in one case.

From a utilization point of view, the list items were well completed. If the entire list has meaning for a particular patient, it can be expected that it will be completed. The "zero" and "no" options do not appear to be well utilized in this domain. These responses are not consistent with subsequent responses, when used in screening questions, and these responses are skipped when used as a choice of response in check all that apply. The pattern of utilization in skip-logic questions is of concern. Responses to items for patients who should have been screened out cannot be interpreted analytically, because it is not known which item they answered incorrectly: the screener or the subsequent item. Therefore, the use of no, zero, and skip logic will need to be addressed carefully in the training.

5.2.4 Domain IV—Cognitive Status

The majority of the Cognitive Status section applies only to patients who were not comatose—96 percent of the patients. (Twenty-two patients were reported as comatose.) The skip pattern in this section is complex—the answer to one item determined which item should have been addressed next. There were five subdomains:

1. Brief Interview for Mental Status (BIMS)

2. Observational Assessment (for those who did not attempt BIMS)

3. Confusion, Behavioral Signs and Symptoms, Mood, which included the Patient Health Questionnaire (PHQ2)

4. Fatigue

5. Pain

Three of these subdomains began with screening questions. The average percent missing in each setting ranged from 4 to 22 percent, as shown in ***Table 5-10***.

Table 5-10
IV. Cognitive status: Percent missing responses to items addressed to all patients

Item	Item Name	AH (frequency 102) percent missing responses	LTCH (frequency 187) percent missing responses	IRF (frequency 203) percent missing responses	SNF (frequency 50) percent missing responses	HHA (frequency 39) percent missing responses
IVA1	***A. Comatose***	10	21	5	10	13
IVF1	F1. Mood Interview Attempted?	11	13	7	21	16
IVG1	G1. Fatigue Interview Attempted?	7	15	10	24	16
IVH1	H1. Pain Interview Attempted?	7	10	7	22	4
Domain IV	Average % Missing	**9**	**15**	**7**	**19**	**12**

BIMS started with a screening question, "BIMS interview attempted?" The average percent missing of this screening question did not exceed 21 percent for any setting. Among respondents who answered the screening question, the proportion that responded that BIMS was attempted was 90 to 100 percent, except at LTCHs, where it was 61 percent of admissions and 38 percent of discharges. At least 90 percent of those expected to answer BIMS, based on their "yes" reply to "BIMS interview attempted" responded to the BIMS items. Respondents had the same response rate across all six BIMS items. Across settings, there were only 20 respondents replying to the BIMS items who had not completed the screener.

The Observational items were asked about patients who had not attempted a BIMS interview. The number of patients for whom a BIMS interview was not attempted are displayed ***Table 5-11***.

Table 5-11
Responses to "BIMS Interview Attempted?" by setting and assessment total responses, "No" responses, and percent "No"

Care setting/survey type	Total response to *BIMS interview Attempted?*	Responses selecting *No*	Percent of total responding *No*
Acute Hospital Discharge	94	9	10
HHA Admission	26	2	8
HHA Discharge	9	2	22
IRF Admission	90	5	6
IRF Discharge	97	33	34
LTCH Admission	96	37	39
LTCH Discharge	33	53	62
SNF Admission	42	4	10
SNF Discharge	2	0	0

BIMS, Observational Assessment

These items were recorded for all patients during the pilot test. The AHs, IRFs, and LTCHs, had between 33 and 77 percent of responses to short-term memory recall missing. However, the memory recall items were answered for approximately 190 patients.

Table 5-12 explains the response to one of the observational assessment items, short-term memory recall, by setting and assessment. The first column of data indicates the number of patients whose responses indicated that BIMS was not attempted. The last column is the total number of respondents to short-term memory recall. The last column includes the patients in the middle column. Among AH discharge assessments, shown in the first row of the table, 9 assessments had responses indicated the BIMS was not attempted. All 9 of these patient assessments should have included responses to the short-term memory recall item. Only 4 of them did. Surprisingly, there were 28 total responses on AH discharge assessments to the short-term memory recall item.

The pattern of responses by all respondents is described in the following paragraphs. These results are skewed towards higher-level functioning because of the responses for patients not expected to answer the items.

Table 5-12
Screened and unscreened responses to short-term memory recall

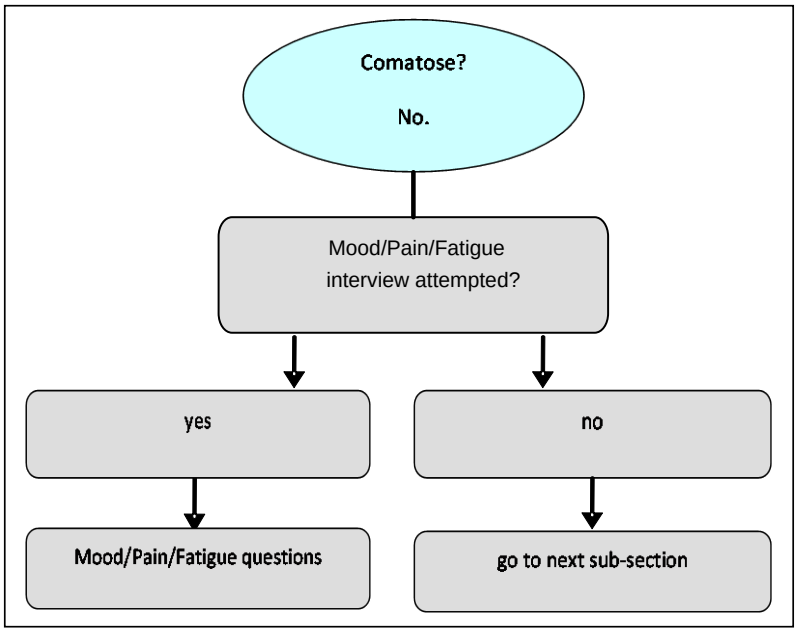
Care setting/survey type	BIMS not attempted	Patients with BIMS not attempted that responded to short-term memory recall	Total number of respondents to short-term memory recall
Acute Hospital Discharge	9	4	28
HHA Admission	2	2	21
HHA Discharge	2	2	8
IRF Admission	5	2	25
IRF Discharge	33	22	30
LTCH Admission	37	17	41
LTCH Discharge	33	20	30
SNF Admission	4	2	39
SNF Discharge	0	0	2

The *Confusion Assessment Method* subdomain consisted of four items. These were filled out for all or nearly all patients in most sites, with the exception of LTCH discharges, and HHA admission and discharge assessments, which were missing in 10 to 15 percent of the cases in each setting, for each type of assessment.

The *Behavioral Signs and Symptoms* were completed for nearly all noncomatose patients, except for 11 percent of HHA discharges and 18 percent of LTCH discharges.

As shown in ***Figure 5-1***, *Mood*, *Fatigue*, and *Pain* subsections had similar structures:

Figure 5-1
Mood, fatigue, and pain subsections structure



The screening question determining whether a mood interview was attempted was answered in all settings. Among those responding to the items, AHs and HHAs had the highest proportion of patients interviewed—approximately 90 percent—and LTCHs and IRFs reported attempted mood interviews on closer to 60 percent of respondents. The mood interview items, however, were answered by 60 more respondents than answered "yes" to the screening question.

The screening question: "During the past 2 weeks, have you been bothered by any of the following problems: Little interest or pleasure in doing things." For those responding "yes", the follow-up was "how many days in the last 2 weeks?" The 25 percent of total respondents that reported not at all were inconsistent with the screener. The largest factor in the apparent contradiction is probably that 27 percent of respondents to the "how many times…little interest" item had not answered the screening question ("have you been bothered by...little interest") with "yes."

When the fatigue interview was attempted, fewer than 2 percent of the following fatigue responses, for expected respondents, were missing. Unexpected responses to the fatigue item accounted for 16 percent of total responses.

Pain was captured by both patient self-report and observational items. For patients for whom the *Pain* interview was attempted, there was an additional screener question: "Have you had pain…?" If the answer was positive, three further items were asked about pain severity and effect of pain on function. The pain interview attempted question was completed for nearly all patients in all sites—no more than 10 percent were missing. Among those, a median of 85 percent in each site responded that yes, the pain interview was attempted. Among those who attempted the interview, the next item, presence of pain, was completed for nearly all participants. The pain severity and function items were only asked of those who had pain present. The severity and function pain items were generally all asked or all skipped for a given patient, and the percent missing of expected responses was greater than 16 percent for all but one site. Unexpected responses to pain items accounted for only 10 percent of total responses.

The Pain interview was not attempted for 15 percent of patients; therefore a pain observation assessment was to be completed for those patients. However, the observational assessment was completed for only 60 percent of the expected respondents (those who did not complete a pain interview.) Among PACs, admissions had a higher percent of observational assessments than discharges.

The Cognitive Status Domain had several sets of items preceded by screening questions, as shown in Table 5-10, above. The BIMS screening question had a high response rate and was the most accurately used screening question on the instrument in terms of the utility of the "no" response. Fewer than 5 percent of those responding "no" to BIMS Interview Attempted responded to the BIMS items. The "yes" response to the screener was also used comparatively accurately, with no more than 12 percent of "yes" respondents failing to respond to BIMS items. The observational assessment for those not doing BIMS was answered by 145 respondents who should not have answered it. The Mood Interview items were answered by 60 respondents who had indicated that they did not attempt it. Two types of observational responses, for cognitive status and for pain, were missing as many as half the responses that were screened into those subdomains.

All settings were able to collect these items. However, the skip logic is complex and attention needs focus on answering of items by the appropriate respondents. The training needs to focus on flow of items to improve response rates for the desired respondents, and eliminate responses by those to whom items do not pertain.

5.2.5 Domain V—Impairments

The Impairments domain was applicable to noncomatose patients in all settings for admissions and discharges. The items are presented in ***Table 5-13,*** for 559 of the 581 patients in the pilot study. Neither admission nor discharge assessments consistently had higher response rates than the other. We found that the average percent missing responses for this domain varied by site more than by setting. In each setting, there were one or more sites missing 5 percent or fewer responses, on average, to impairment items. Low missing response rates were found in both admission assessments and discharge assessments.

The *Bladder and Bowel Management* subsection was to be filled out for all patients in all setting assessments. The first item, does the patient use a device or require catheterization, had the highest response rate in this subsection, over frequency and needing assistance with the device. The frequency of incontinence item choice "renal failure" was selected only in the LTCH setting.

Two *Swallowing* items were also to be answered for all patients for all types of assessments. In most settings, either both or neither swallowing items were answered.

The four *Hearing, Vision and Communication* items varied more across sites than across settings. At least one site in each setting was missing 4 percent or fewer responses to these items. In two of the three LTCHs, discharge assessments were more complete than admission assessments.

Range of Motion items had the most complete answers in this domain. They were answered on nearly all acute hospital discharges and on at least 85 percent of assessments in other settings, except two of the LTCHs mentioned.

Weight-bearing items were completed for the same patients as the Range of Motion items.

Respiratory Status and *Endurance* items were both answered for at least 85 percent of respondents for all settings except the SNF.

The impairments domain had high response rates, compared to other domains, in all settings for all items. ***Table 5-14*** shows the response rates for the bowel and bladder incontinence items answered by those "passing" the screening question, whether the patient has any impairments in bowel or bladder management. Missing rates were low for these items and there were few extraneous responses for patients who did not "pass" the screening question.

Table 5-13
V. Impairments: Percent missing responses by setting

Item	Item Name	AH (frequency 102) percent missing responses	LTCH (frequency 187) percent missing responses	IRF (frequency 203) percent missing responses	SNF (frequency 50) percent missing responses	HHA (frequency 39) percent missing responses
	Bladder and Bowel Management					
VA1A	A1a. Bladder Incontinence	7	16	5	4	13
VA1B	A1b. Bowel Incontinence	7	31	7	4	10
VA2A	A2a. Bladder	16	42	11	6	18
VA2B	A2b. Bowel	11	27	5	4	13
VA3A	A3a. Bladder	14	17	5	4	21
VA3B	A3b. Bowel	15	25	6	4	18
	Swallowing					
VB1	B1. Swallowing Disorder Signs and symptoms of possible swallowing disorder.	7	43	5	4	—
VB2	B2. Indicate the person's usual ability to swallow.	7	19	6	4	—
	Hearing, Vision, and Communication					
	Comprehension					
VC1	C1. Understanding verbal content (With hearing aid or device if used)	7	28	7	4	15
VC2	C2. Expression of ideas and wants	7	27	6	4	15
VC3	C3. Ability to see in adequate light (with glasses or other visual appliances):	6	27	7	4	13
VC4	C4. Ability to hear (with hearing aid or hearing appliance if normally used):	6	27	6	4	13
	Upper Extremity Range of Motion					
VD1A	D1a. Left Shoulder	6	19	4	8	10
VD1B	D1b. Left Elbow	5	19	5	6	13
VD1C	D1c. Right Shoulder	5	19	4	6	10
VD1D	D1d. Right Elbow	6	19	6	6	10
	Weight-bearing					
VE1A	E1a. Left Upper Extremity	7	20	8	4	13
VE1B	E1b. Right Upper Extremity	6	19	6	4	13
VE1C	E1c. Left Lower Extremity	6	19	5	4	15
VE1D	E1d. Right Lower Extremity	6	19	5	4	13
VE1E	E1e. Buttocks	7	20	5	4	21
	Respiratory Status					
VF1	F1. When was the patient dyspneic or noticeably Short of Breath during the past 2 days?	7	41	4	4	10
	Endurance					
VG1	G1. Did the patient have to stop and rest two or more times when walking or wheeling 50 feet (15 meters) in the last 2 days?	5	16	5	6	10
Domain V	Average % Missing	8	24	6	5	14

Table 5-14
Skip logic of bowel and bladder management subsections: Incontinence items by setting

Item	Skip Logic	Result	AH Discharge (n=102)	LTCH Discharge (n=65)	IRF Discharge (n=100)	SNF Discharge (n=5)	HHA Discharge (n=9)	Overall (n=281)
VA2a. Bladder	Percent missing of those Responding No to VA1B (Bowel Incontinence)	—	—	—	—	—	—	—
—	—	Expected Responses	85	26	90	3	8	395
—	—	Total Responses	86	39	92	3	8	453
—	—	% missing	11	19	6	25	11	
VA2b. Bowel	Percent missing of those Responding No to VA1B (Bowel Incontinence)	—	—	—	—	—	—	—
—	—	Expected Responses	90	31	96	4	8	424
—	—	Total Responses	91	53	99	4	8	502
—	—	% missing	5	3	0	0	11	—

5.2.6 Domain VI—Functional Status

Functional status items were asked in all settings for all types of assessments about noncomatose patients. Percent missing for items addressed to all patients are in ***Table 5-15***. The first items on *Self-Care* were addressed to all patients. For the toilet hygiene, oral hygiene, and eating items, the percent missing varied considerably by setting from 5 percent in IRFs to 50 percent in the SNF. The tube feeding item was only completed for patients for whom tube feeding was the primary mode of nutrition.

The *Functional mobility* subsection had seven questions applicable to all patients and two additional items for those who primarily used a wheelchair. The pattern of nonresponse was similar for all items. The LTCHs had high percent missing, from 45 to 100 percent, which is likely to be due to the acuity level of their patients; the AHs had the lowest percent missing, 2 or 3 percent, which suggests that the acute care setting is able to gather these data at the point of discharge.

The remainder of the functional status section consisted of items specific to each of five levels of function. Items were to be answered for the usual level of functioning of the patient on the day of discharge and the previous day. To maximize efficiency, respondents were asked to record responses for the most appropriate level of functional items to answer, and respond to the

Table 5-15
VI. Functional status: Percent missing responses by setting

Item	Item Name	AH (frequency 102) percent missing responses	LTCH (frequency 187) percent missing responses	IRF (frequency 203) percent missing responses	SNF (frequency 50) percent missing responses	HHA (frequency 39) percent missing responses
	A. Self-Care					
VIA1	A1. Toilet Hygiene	6	51	5	16	13
VIA2	A2. Oral Hygiene	6	44	5	14	13
VIA3	A3. Eating	6	53	6	14	13
	B. Functional Mobility					
VIB1	B1. Walk 50 ft	9	77	22	28	28
VIB2	B2. Walk in Room Once Standing	8	74	17	22	23
VIB3	B3. Toilet Transfer	7	75	10	16	18
VIB4	B4. Chair/Bed-to-Chair Transfer	7	68	6	14	21
VIB5	B5. Sit to Stand	10	69	8	18	18
VIB6	B6. Lying to Sitting on Side of Bed	7	60	7	14	18
VIB7	B7. Mode of Mobility: Wheelchair?	12	36	8	14	21
VIB8	B8. Wheelchair Users Only: Wheel 50 ft.	47	83	81	42	92
VIB8B	B8b. Wheelchair Users Only: Wheel 50 ft—If not attempted	16	34	35	40	72
VIB9	B9. Wheelchair Users Only: Wheel in Room Once Seated	49	83	79	38	92
	Frailty/Life Expectancy					
VIH1	A1. Surprise if patient was readmitted in the next 3-6 months	10	15	6	12	21
VIH2	A2. Surprise if patient died in the next 6-12 months	9	16	6	12	15
Domain VI	Average % Missing	14	56	20	21	32

other levels with "not applicable." Among the 472 respondents to the function level items, 69 percent answered with numeric ratings for one function level, and 28 percent responded with numeric ratings for more than one function level. In one LTCH, more respondents completed ratings for two or three levels than completed ratings for only one function level. The distribution of the number of function levels completed by site is displayed in ***Table 5-16***. Also shown in Table 5-16 is the number of respondents who did not respond in any manner to any of the functional level items. There were 109 such missing responses, half of which were in LTCHs. This may indicate that function is not an important descriptor for LTCH patients.

Frailty/Life Expectancy

The IRFs and the SNF answered these items most frequently, compared to other settings. They were missing in less than 15 percent of responses. LTCHs and HHAs were missing responses to these items in up to 50 percent of cases.

The functional status items were answered in all settings, although some answered with "not attempted" more than others. The initial items on toilet hygiene, oral hygiene, and eating

had a wide range of percent missing from only 5 percent missing responses in AHs and IRFs, but 50 percent missing in LTCHs. Functional mobility items had higher proportions of missing responses. Frailty and life expectancy items were reported between 79 and 94 percent of cases, on average, per setting. Settings had some difficulty with items specific to a given level of functioning; the percent of respondents who skipped the level items and who answered too many level items were high. Highlighting the instruction section of the functional level items would likely improve the correct response rate to those items.

5.2.7 Domain VII—Discharge Status

Response rates in this domain varied by item, as shown in ***Table 5-17***.

The rate of *discharge date and location* completion varied by site and setting. The IRFs and HHAs recorded the discharge date for all but 1 or 2 patients. The AHs ranged from 2 to 13 percent missing, and the LTCHs from 2 to 86 percent missing.

Four items were asked of respondents discharged to a private residence, other community-based setting, or hospice care. The items addressed patient needs, ability to pay for medication, and transportation. Responses for discharges from AHs and IRFs, which accounted for more than 90 percent of possible responses, were missing fewer than 10 percent of responses.

The *mode of transportation* information was missing in half of AHs, nearly all LTCHs, and up to 25 percent of HHAs and IRFs.

Discharge care information was missing for 20 to 100 percent of respondents at each site. A set of 6 items, one for each type of facility, were asked about discharge care options. For each facility type, the responder was to indicate if that setting was deemed appropriate by the provider, had a bed available, and was refused by patient/family. The items were intended to be "check all that apply." Responses to these items were low. Excluding the SNF, the minimum percent missing was 80 percent, but the sites with most of the discharges—AHs, LTCHs, and IRFs—had between 30 and 100 percent missing responses. The response "deemed appropriate by the provider" was the only response used more than 20 times in total, across all settings. The other choices were not selected or were selected only a small number of times in each setting. Following that set of items was provider information. Overall, 40 percent of cases were missing responses to provider name and 50 percent to provider setting.

Table 5-16a
Number of respondents completing level of functioning by number of levels completed: Acute and long-term hospitals

Number of functional levels completed per patient	All sites	Alexian Brothers Medical Center AH discharge	Edward Hospital AH discharge	Rush-Copley Medical Center discharge	Kindred - Chicago Central LTCH admission	Kindred - Chicago Central LTCH discharge	Kindred Sycamore LTCH admission	Kindred Sycamore LTCH discharge	RML Specialty Hospital LTCH admission	RML Specialty Hospital LTCH discharge
1	325	16	8	37	0	0	26	6	5	12
2	49	7	2	3	12	1	1	0	0	4
3	69	8	1	0	16	27	0	0	0	3
4	8	1	1	0	0	2	0	0	0	0
5	6	1	2	0	0	0	0	0	0	0
Activity not attempted	15	2	1	5	0	0	0	0	1	2
Response missing	109	4	1	2	9	1	15	1	37	6
Total respondents	581	39	16	47	37	31	42	7	43	27

Table 5-16b
Number of respondents completing level of functioning by number of levels completed: Inpatient-rehabilitation facilities, SNFs, and home health agencies

Number of functional levels completed per patient	All sites	Alexian Brothers Medical Center IRF admission	Alexian Brothers Medical Center IRF discharge	Marianjoy Rehabilitation Hospital IRF admission	Marianjoy Rehabilita-tion Hospital IRF discharge	Manor Care SNF admission	Manor Care SNF discharge	Edward Hospital PAC HHA admission	Edward Hospital PAC HHA discharge	VNA of Fox Valley HHA admission	VNA of Fox Valley HHA discharge
1	325	40	49	31	37	38	2	0	1	16	1
2	49	5	1	6	0	1	0	4	1	1	0
3	69	2	1	3	3	0	0	2	3	0	0
4	8	1	0	0	1	0	0	2	0	0	0
5	6	0	0	0	0	0	0	0	3	0	0
Activity not attempted	15	1	2	1	0	0	0	0	0	0	0
Response missing	109	2	2	11	4	6	3	0	0	5	0
Total respondents	581	51	55	52	45	45	5	8	8	22	1

NOTE: Respondents were to answer items for one of five functional levels with a rating of ability. For the four other functional levels, they were to select a code for "Activity not Attempted." Many patients had more than one functional level completed with ability ratings. The number of functional levels completed with ability ratings per person was calculated, using the first of each set of level items.. This table presents the number of patients who had one or more sets of functional level items completed with rating ability. More than one is considered too many. Also presented is the number of patients for whom "Activity Not Attempted" was selected for one or more levels and other levels were left blank, and the number of patients for whom no answers were completed (response missing).

Table 5-17
VII. Discharge status: Percent missing responses by setting

Item	Item Name	AH (frequency 102) percent missing responses	LTCH (frequency 187) percent missing responses	IRF (frequency 203) percent missing responses	SNF (frequency 50) percent missing responses	HHA (frequency 39) percent missing responses
	A. Discharge Date					
VIIA1	A1. Enter discharge date	7	13	1	6	0
VIIB1	B1. Discharge location	6	15	1	6	0
VIIB2	B2. Home situation	39	31	4	6	3
	C. Patient Needs Assistance					
VIIC1	C1. Patient Lives with at Discharge	54	34	15	8	0
VIIC2	C2. Frequency of Assistance	53	31	11	8	3
VIIC3	C3. Caregiver(s) Availability	56	30	12	8	8
VIIC4	C4. Types of Caregivers	57	34	14	8	8
VIIC5A	C5a. Patient able to pay for meds after discharge	50	29	9	6	5
VIIC5B	C5b. Patients mode of transport to aftercare following discharge	51	32	12	6	5
VIIC6	If Transportation Other, Please specify mode:	99	34	43	10	23
	D. Discharge Care Options					
VIID1	D1. HHC	75	35	26	8	21
VIID2	D2. SNF	60	30	43	8	23
VIID3	D3. IRF	90	33	49	10	21
VIID4	D4. LTCH	100	35	48	10	23
VIID5	D5. Psych Hosp.	99	35	49	10	23
VIID6	D6. Other	93	32	37	10	21
VIID6_D	D6d. If discharge setting other, please specify	84	28	18	10	21
	D7. Discharge Location Information					
VIID7A	D7a. Provider Name	36	21	20	8	13
VIID7B	D7b. Provider Type	41	26	25	8	18
	D7c. Provider City and State					
VIID7C_A	D7c_a. Enter Provider City	41	25	21	8	15
VIID7C_B	D7c_b. Enter Provider State	47	24	22	8	18
	E. Discharge Delay					
VIIE1	E1. Was discharge delayed for at least 24 hrs.	8	21	3	8	3
VIIE2	E2. Reason for Discharge Delay	79	35	44	10	21
VIIE2_5	E2_5. If reason for delay other, please specify	93	34	47	10	23
Domain VII	Average % Missing	59	29	24	8	13

Whether a *discharge delay* occurred was missing in fewer than 15 percent of cases at each AH, IRF, and HHA sites. Half of LTCHs were missing responses. (SNF had only 5 discharges.)

The items in the discharge status domain varied in their completion. The discharge date and location had high response rates except in LTCHs. The first discharge location item, QVIIB1, had a higher response rate than the similar, later item, QVIID7b. Items about whether different types of PAC facilities were considered appropriate discharge locations had poor response rates in some settings, and generally only one of three choices was selected.

5.3 CARE Tool Measurement Attributes

5.3.1 Introduction to Evaluation of CARE Tool Properties

The previous sections described the ability of respondents to utilize the instrument in the intended manner. This section focuses on the functional status items, which are designed to work together to describe self-care function and mobility. This section describes how well items work together to describe these constructs, considering rating scale function, unidimensionality, and item fit.

Rasch analysis is a method of analyzing survey data, where the responses to items utilize rating scales and those items are seen as relating to a particular construct. Generally, item responses are added together to form a total score. These total scores are then used to compare patients across time e.g., from admission to discharge or to determine differences between patients e.g. compare HHA patients to SNF patients. However, in order for these comparisons to be valid, these assessments must exhibit the essential properties of measurement: unidimensionality, hierarchical order, and equal interval scaling (unidimensionality, because patient assessment tools capture a single construct such as functional status; hierarchical order, because items on the assessment can be ordered from less to more in a way that is consistent across patients; and equal intervals, because units on a measuring instrument are the same size at all points on the instrument). Total raw scores do not exhibit these essential properties of measurement.

Classical test theory techniques pay less attention to unidimensionality, hierarchical order, and equal interval scaling. Instead they focus on issues of internal consistency, reproducibility, and validity. For example, Cronbach's alpha is commonly reported as evidence of a test's psychometric strength. Yet coefficient alpha is sample-dependent, that is, the value varies depending on the range of abilities (variance) in the sample tested. In addition, the value of coefficient alpha is influenced by: test length, test targeting, missing data, and test homogeneity. The impact of these factors may not always be apparent by observing the obtained alpha, and consequently test quality cannot be inferred from a simple comparison of Cronbach's alpha. Test-retest reliability is frequently reported to demonstrate that responses to the instrument remain stable across testing sessions. Yet this says little about whether the construct (as operationalized by the items) remains stable over the range of people for whom the test is intended. Are hard items hard for everyone? While internal consistency and reproducibility are important features to evaluate with any instrument, they are not, in and of themselves, the essential features of measurement.

Rasch measurement (part of a family of methods called Item Response Theory) is an approach to analyzing patient assessment data that allows an examination of how well the data collected with a patient assessment exhibit the essential features of measurement. Any person's score on a test can be expressed as a ratio of probabilities. That is, the probability that they succeed on the item against the probability that they fail the item is p/(1-p). This relationship can take values between 0 and infinity (∞) and so has a nonlinear relationship with the underlying variable being measured which can be thought to be essentially continuous. Taking the log of this relationship, log(p/(1-p)), creates values that extend from -∞ to +∞, forming a linear relationship with the underlying variable. Rasch showed a unique feature of this model that could be used for determining the difference between the ability/difficulty of two different people or items.

Specifically, he showed that person ability could be determined solely from the observed responses on an assessment and by the ratio between the ability parameters of the two people; that is, estimates of person ability are not influenced by which items are used. Exactly the same relationship can be shown for estimating item difficulty, i.e., they can be determined from observed responses and the ratio of the difficulty parameters of the items; they are not influenced by which people took the items. We can capitalize on this feature inherent within Rasch analysis to simplify data collection across a broad range of patient abilities from very impaired to very able. An assessment with enough items to capture this range would be long and burdensome. By utilizing Rasch analysis, we are able to build an instrument that can have many items but only a smaller portion of which is administered to any particular patient. In addition, since patient ability can be measured regardless of which items are taken, different items may be administered to the same patient at admission and discharge and still be comparable.

In recent years, item response theory (IRT) has become increasingly used in both test equating and item banking procedures. For example, the AM-PAC and the PROMIS network both utilize IRT to develop short forms and for adaptively administered item banks.

5.3.2 Evaluation of CARE Instrument

We evaluated a measure of patient functioning from the CARE tool pilot tested in this study. It included 42 items covering the domains of self-care and instrumental activities of daily living (IADLs) and mobility. Given that the existing PAC instruments have only 18 or fewer function items, 42 items represents a considerable increase in test length. The challenge for a single instrument for post-acute care is to measure function in the most impaired patients in an LTCH facility to quite able patients receiving home health care. By utilizing the Rasch model however, it is not necessary to administer all the items to all patients. We administered a core set of items to all patients, and then administered supplemental items that were targeted at the patient's level of ability. The core set of items consisted of four self-care items (toilet hygiene, oral hygiene, eating, and tube feeding) and eight mobility items (walk 50 feet, wheel 50 feet, walk in room once standing, wheel in room once seated, toilet transfer, bed to chair transfer, sit to stand, and lying to sitting on the side of the bed). There are an additional 18 supplemental self-care and IADL items and an additional 13 supplemental mobility items. See ***Table 5-18*** for a list of core and supplemental items.

Table 5-18
CARE self-care, IADL, and mobility items

Item	Core	Supplemental
Self-care	Toilet Hygiene	Sponge bathe
	Oral Hygiene	Upper body dressing
	Eating	Shower/Bathe self
	Tube Feeding	Picking up an object
		Lower body dressing
IADL	—	Laundry
		Make light meal
		Dishwashing by hand
		Dishwashing machine
		Wipe down surface
		Telephone—answering
		Telephone—placing call
		Medication management—oral meds
		Medication management—inhaled meds
		Medication management—injectable meds
		Light shopping
		Use public transportation
		Drive a car
Mobility	Walk 50 feet	Sit to lying
	Walk in room once standing	Roll left or right
	Toilet transfer	Step up 1 step or curb
	Chair/Bed to chair transfer	Wheel short ramp
	Sit to stand	12 steps interior
	Lying to sitting on side of bed	4 steps exterior
	Wheel 50 feet	Walk 100 feet
	Wheel in room once seated	Wheel 100 feet
		Wheel long ramp exterior
		Get in and out of car
		Walk one block
		Wheel a block

All self-care and most of the mobility items (26 items) were scored on 6-point rating scale from 6-independent to 1-dependent. The IADL items and three of the more challenging mobility items (16 items) were scored on a 4-point rating scale, ranging from 4-independent to 1-dependent. Both scales are designed to capture differences in the amount of assistance a patient requires to complete everyday tasks. See ***Table 5-19*** for a complete description of the rating scales.

Table 5-19
Rating scales

6-point rating scale	4-point rating scale
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 the 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 less than half of the time. 2. Substantial/Maximal Assistance—Helper does MORE THAN HALF the effort. Helper lifts or holds the trunk or limbs more than half of the time. 1. Dependent—Helper dos ALL the effort. Patient does none of the effort to complete the task.	4. Independent—Person completes activity by him/herself with no assistance from a helper 3. Minimal Assistance—Person completes the activity with assistance. Helper provides less than half of the effort. 2. Maximal Assistance—Person completes the activity with assistance. Helper provides more than half of the effort. 1. Dependent—Helper does ALL of the effort. Person does none of the effort to complete the task.

5.3.3 Rating Scale Step Structure

Examination of the effectiveness of the CARE self-care+IADL and mobility scales to demonstrate the essential features of measurement begins with an examination of the rating scales. Each step of the rating scale is designed to capture an increasing level of dependence on another person for assistance. Thus, on average, we expect more impaired patients to receive more "2"s and "3"s and more able patients to receive more "5"s and "6"s. If we examine the probability of receiving a score of 2, the probability should be greater for more impaired patients and less likely for more able patients. Similarly, the probability of receiving a score of 5 should be greater for more able patients and less for more impaired patients. Thus, if the rating scale steps are used by raters as expected, we should see discrete probability curves for each step. These data are presented in ***Figures 5-2 and 5-3***. These represent the rating scale structures for the 6-point and 4-point scales for the self-care+IADL items and the mobility items, respectively. In Figure 5-2, all the curves for both the 6- and 4-point rating scales are discrete and ordered. In Figure 5-3, step 5 is hidden beneath step 4, which is somewhat prominent. This suggests that step 5 "set up assistance" is not very often used and does not help distinguish amount of assistance in that region of ability. It is likely that set-up assistance is not as relevant for mobility items as it is for self-care items.

Figure 5-2
Self-care+IADL rating scale step structure (4-point and 6-point)

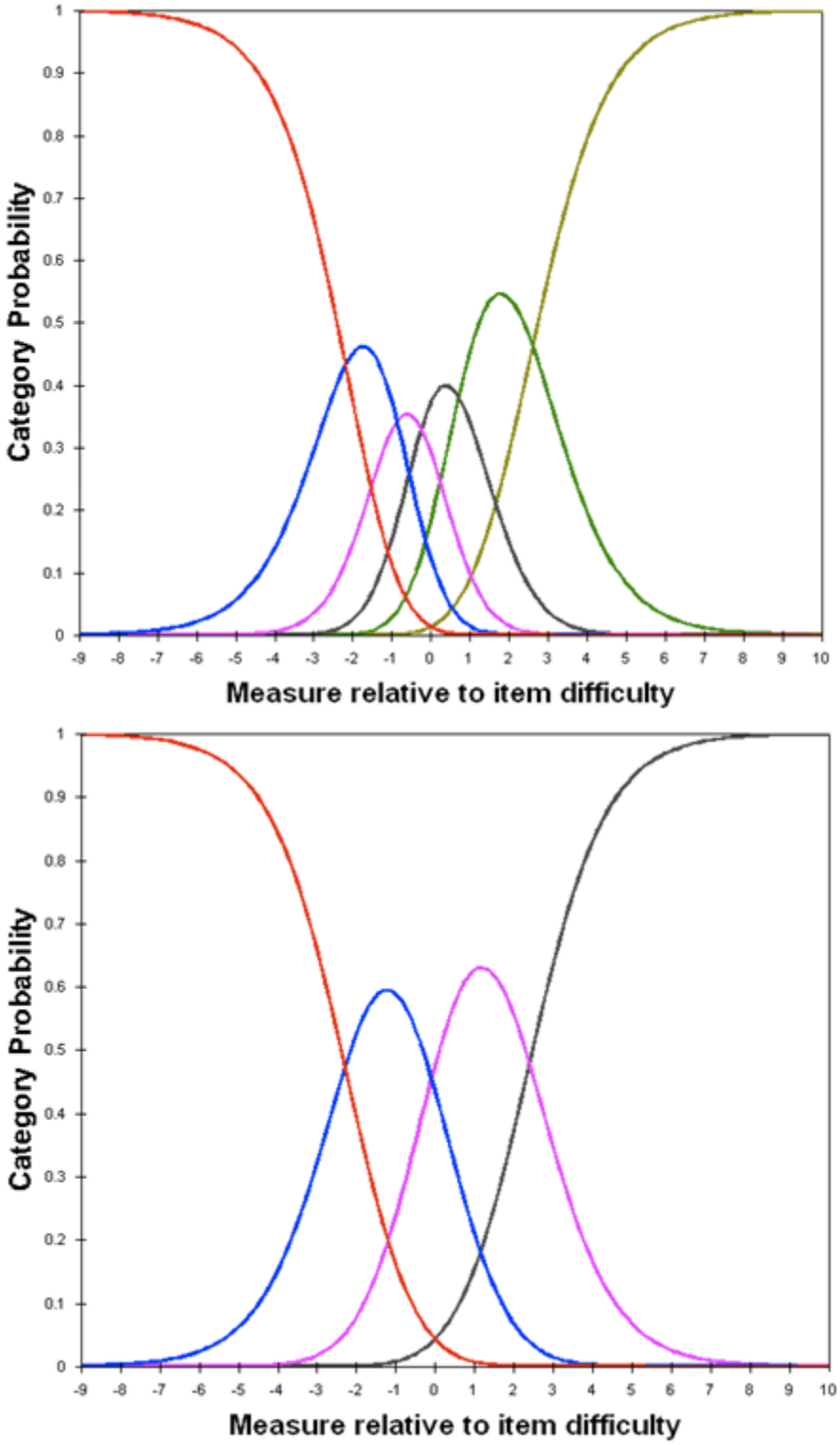
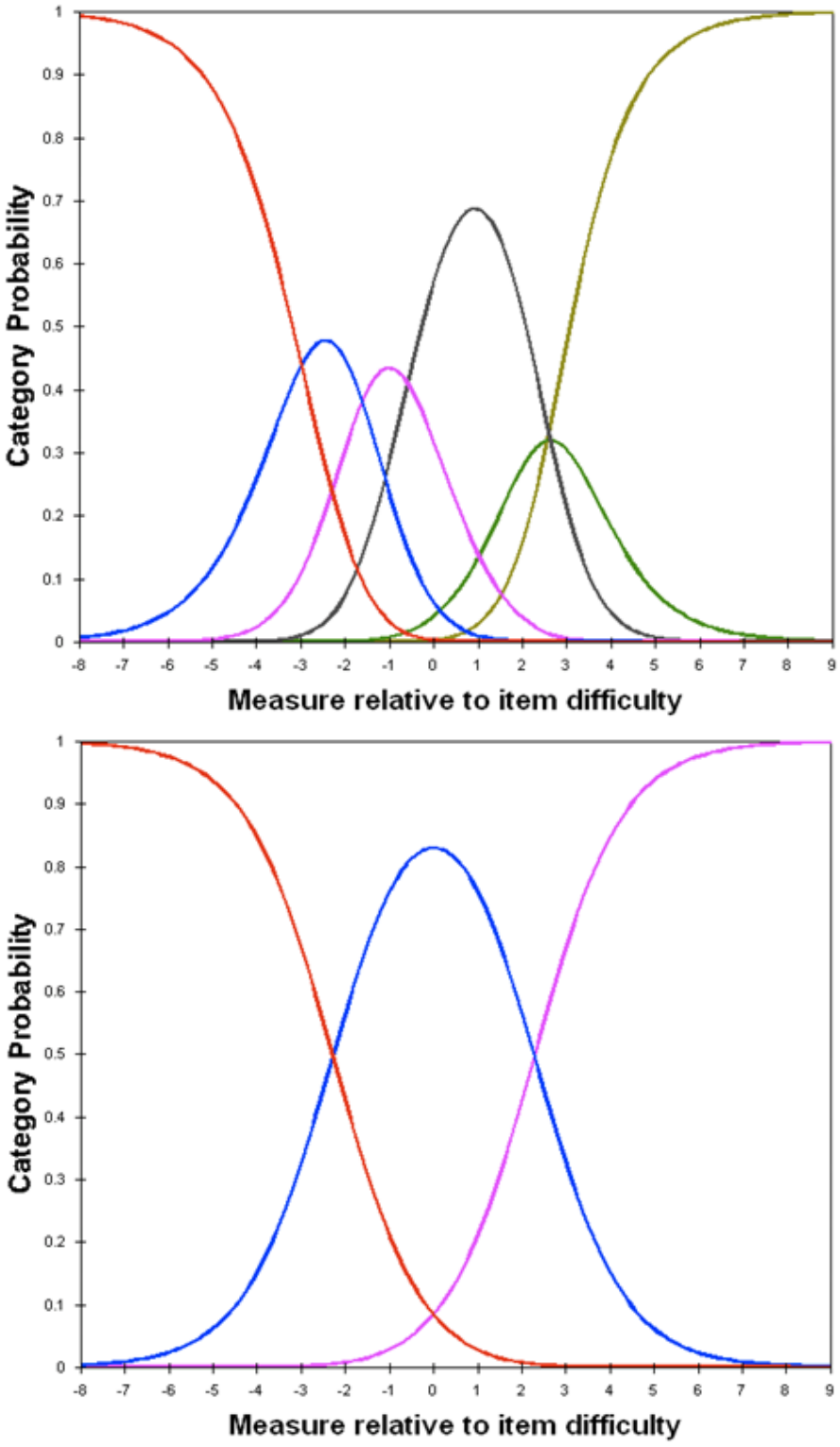


Figure 5-3
Mobility rating scale step structure (4-point and 6-point)



Tables 5-20 and 5-21 present these data numerically. It is important to note in these tables that both the structure calibrations and the category measures proceed in an ordered fashion, suggesting that the probabilities of receiving a particular score increases as expected across the range of patient abilities. Again, the step 5 category is submerged, but not disordered, indicating that for patients in this study, set-up assistance is never more likely than supervision. It may be that for mobility tasks, there is simply very little set-up assistance required. That is, this level of assistance does not help discriminate patients of higher and lower mobility function. To examine this hypothesis, we reanalyzed the data, examining it as if patients receiving a score of 5 had received a score of 6. Since the "5" category is no longer observed, we look at other data to examine the impact of this rescoring on measurement quality. The separation index (SI) is a ratio of the standard deviation (adjusted for measurement error) to the root mean square error (RMSE). It is an indication of the precision with which the patients are being measured. A comparable and perhaps more understandable statistic is the patient reliability value which can ranges from 0.0 to 1.0 and can be interpreted in much the same way as Cronbach's alpha coefficient, an indicator of internal consistency, or reliability.

In ***Table 5-22***, we see that the SI and patient reliability values change from 3.26 and .91 to 2.65 and .88 after rescoring. In fact, the adjusted SD is virtually unchanged suggesting that the 5-point scale is able to detect the same amount of variation in patients as a 6-point scale, indicating that indeed, the 5th step added little to distinguishing patient level of functional mobility. The RMSE is marginally (.13 logits) larger, suggesting the 5-point scale is marginally less precise than the 6-point scale. However, this is to be expected since removing one rating scale effectively reduces the length of the test by 15 percent.

Table 5-20
Self-care+IADL rating scale step structure (4-point and 6-point)

CATEGORY LABEL	SCORE	OBSERVED COUNT	%	OBSVD AVRGE	SAMPLE EXPECT	INFIT MNSQ	OUTFIT MNSQ	STRUCTURE CALIBRATN	CATEGORY MEASURE	
1	1	163	5	-1.72	-1.83	1.40	1.50	NONE	(-3.00)	1 Dependent
2	2	215	7	-1.13	-1.00	.72	.73	-1.66	-1.48	2 Maximum assistance
3	3	236	7	-.32	-.33	.88	.88	-.75	-.54	3 Moderate assistance
4	4	310	10	.41	.40	.72	.68	-.25	.29	4 Supervision
5	5	436	14	1.23	1.30	1.05	1.03	.48	1.50	5 Setup
6	6	336	11	2.77	2.67	1.00	1.05	2.18	(3.40)	6 Independent

CATEGORY LABEL	SCORE	OBSERVED COUNT	%	OBSVD AVRGE	SAMPLE EXPECT	INFIT MNSQ	OUTFIT MNSQ	STRUCTURE CALIBRATN	CATEGORY MEASURE	
1	1	14	1	-1.78	-2.83	2.14	2.01	NONE	(-3.47)	1 Dependent
2	2	26	1	-.57	-.62	1.29	1.43	-2.29	-1.22	2 Maximum assistance
3	3	47	2	1.37	1.65	1.70	2.46	-.10	1.18	3 Minimal assistance
4	4	84	3	4.63	4.67	1.27	1.19	2.39	(3.55)	4 Independent

Table 5-21
Mobility rating scale step structure (4-point and 6-point)

CATEGORY LABEL	SCORE	OBSERVED COUNT	%	OBSVD AVRGE	SAMPLE EXPECT	INFIT MNSQ	OUTFIT MNSQ	STRUCTURE CALIBRATN	CATEGORY MEASURE	
1	1	179	3	-2.68	-2.99	1.88	1.96	NONE	(-4.05)	1 Dependent
2	2	264	5	-2.08	-1.76	.68	.67	-2.76	-2.31	2 Maximum assistance
3	3	401	7	-.51	-.48	.79	.76	-1.54	-.96	3 Moderate assistance
4	4	850	16	.84	.76	.68	.68	-.60	.87	4 Supervision
5	5	259	5	1.78	1.95	1.42	1.09	2.53	2.49	5 Setup
6	6	330	6	3.37	3.31	.99	.94	2.37	(3.93)	6 Independent

CATEGORY LABEL	SCORE	OBSERVED COUNT	%	OBSVD AVRGE	SAMPLE EXPECT	INFIT MNSQ	OUTFIT MNSQ	STRUCTURE CALIBRATN	CATEGORY MEASURE	
2	2	4	0	-2.97	-3.73	1.56	1.78	NONE	(-3.39)	2 Maximum assistance
3	3	9	1	-.27	.01	1.30	1.04	-2.28	.00	3 Minimal assistance
4	4	3	0	1.24	1.43	1.37	1.46	2.28	(3.39)	4 Independent

Table 5-22
Mobility scale psychometrics (for 6-point and revised scoring)

Rating Scale Structure 123456

	RAW SCORE	COUNT	MEASURE	REAL ERROR	INFIT MNSQ	INFIT ZSTD	OUTFIT MNSQ	OUTFIT ZSTD
MEAN	25.3	6.7	-.56	.62	.88	-.5	.87	-.5
S.D.	13.4	2.2	2.23	.20	1.01	1.8	1.02	1.8

REAL RMSE	.65	ADJ.SD	2.13	SEPARATION	3.26	PATNT	RELIABILITY	.91

Rating Scale Structure 123466

	RAW SCORE	COUNT	MEASURE	REAL ERROR	INFIT MNSQ	INFIT ZSTD	OUTFIT MNSQ	OUTFIT ZSTD
MEAN	25.2	6.7	.25	.75	.89	-.4	.87	-.5
S.D.	11.2	2.1	2.21	.22	1.04	1.7	1.03	1.7

REAL RMSE	.78	ADJ.SD	2.07	SEPARATION	2.65	PATNT	RELIABILITY	.88

The preceding figures and tables describe the performance of the rating scales, on average, across all items. We can also examine the performance of the rating scale item by item. This information is presented in ***Tables 5-23 and 5-24***. The column labeled "average measure" indicates the average difficulty of that rating scale step for that item. Rating scale steps marked with an "*" indicate steps where the rating scale step does not monotonically increase from the

previous step for a particular item. We see that for the self-care+IADL items, there are six items for which a rating scale step can be considered disordered. With the exception "tube feeding" these are IADL items with relatively low counts, indicating that these items were only administered to a few patients. It may well be that these perturbations are relatively minor and with more data would not indicate a problem with how well the rating scale is operating for these items. For the mobility items we see disordered steps for only 4 items, step up 1 step, wheel a short ramp, walk up 12 steps, and walk 100 feet. These are overall, minor perturbations and the solid person reliability estimates suggest they have little effect on the overall integrity of the scale. We conclude that the CARE rating scales steps are working effectively to describe different levels of patient function.

5.3.4 Construct Definition (Validity)—Item Hierarchy

A key feature of essential measurement is hierarchical order. Specifically, different functional status items require different degrees of ability in order to perform them independently. Simply stated, some items are harder than others. More importantly, however, the ordering of items from hardest to easiest should make clinical sense, should effectively cover the range of people to be measured, and should remain consistent across the range of persons that are measured. That is, hard items should be harder for everyone; easier items should be easier for everyone. ***Tables 5-25 and 5-26*** present the self-care+IADL and mobility items in hierarchical order, such that a larger measure implies a more challenging items (see column labeled "measure"). Measures are reported in logits and may take negative values. However, this simply means that the item is below (easier than) the mean value of the item difficulties, whereas a positive value means that item is harder than the mean item difficulty. The ordering of items from hardest to easiest, defines the operational definition of the construct being captured. For self-care+IADL, driving a car, doing laundry and managing injectable medications are the most challenging items for this patient group, picking up an object, showering, and toilet hygiene are moderate level activities, oral hygiene, eating, and answering the phone are very easy items. This hierarchy reflects what has been found for other functional rating scales. Similarly, for the mobility scale, walking a block, getting in and out of a car, and steps are challenging items; walking 50 feet and transfers are moderate items; and moving from lying to sitting and sitting to lying are easy items. A number of the wheelchair items appear to be remarkably easy. There are other reasons to be concerned about these items (discussed below) but these items are administered to a smaller percentage of patients (see column labeled "count") and, it would appear, only administered to patients who are already highly proficient in the use of a wheelchair. (An item is "easy" when everyone scores high on it). This is likely a consequence of the short data collection period and limited sample during this pilot study.

Table 5-23
Self-care+IADL distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	%	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
43	1	1	91	23	-2.92	.20	1.0	-.62	QVIA1_Toilet_Hygiene	1 Dependent
	2	2	45	11	-1.32	.08	.3	-.18		2 Maximum assistance
	3	3	54	14	-.56	.08	.6	-.07		3 Moderate assistance
	4	4	86	22	.12	.06	.5	.04		4 Supervision
	5	5	44	11	.90	.11	.6	.14		5 Setup
	6	6	80	20	3.37	.19	.9	.70		6 Independent
	MISSING	***	69	15*	-2.66	.17		-.35		
44	1	1	42	10	-4.89	.17	1.2	-.62	QVIA2_Oral_Hygiene	1 Dependent
	2	2	22	5	-2.58	.17	.5	-.22		2 Maximum assistance
	3	3	20	5	-1.75	.14	.4	-.14		3 Moderate assistance
	4	4	64	15	-.71	.10	1.1	-.09		4 Supervision
	5	5	153	36	-.26	.07	.7	-.02		5 Setup
	6	6	119	28	2.51	.18	.7	.68		6 Independent
	MISSING	***	49	10*	-2.77	.13		-.30		
45	1	1	28	7	-4.85	.31	6.3	-.54	QVIA3_Eating	1 Dependent
	2	2	18	5	-2.73	.25	1.2	-.24		2 Maximum assistance
	3	3	18	5	-1.81	.21	1.1	-.16		3 Moderate assistance
	4	4	32	8	-1.35	.15	.7	-.16		4 Supervision
	5	5	119	30	-.52	.07	.6	-.13		5 Setup
	6	6	184	46	1.64	.15	.9	.64		6 Independent
	MISSING	***	70	15*	-2.83	.18		-.39		
46	1	1	73	79	-3.30	.17	2.9	-.69	QVIA4_Tube_Feeding	1 Dependent
	2	2	4	4	-.98	.76	3.7	.14		2 Maximum assistance
	3	3	1	1	-.64		.0	.08		3 Moderate assistance
	4	4	3	3	.09	.62	.7	.20		4 Supervision
	5	5	4	4	-.15*	.58	3.7	.22		5 Setup
	6	6	7	8	2.42	1.16	3.8	.61		6 Independent
	MISSING	***	377	80*	.06	.12		.40		

(continued)

Table 5-23 (continued)
Self-care+IADL distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	%	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
13	1	1	52	35	-4.28	.20	.7	-.76	QVIC1_Sponge_Bath	1 Dependent
	2	2	22	15	-1.59	.15	.5	-.02		2 Maximum assistance
	3	3	31	21	-.42	.13	1.1	.19		3 Moderate assistance
	4	4	15	10	-.04	.15	.4	.17		4 Supervision
	5	5	13	9	.76	.34	1.3	.24		5 Setup
	6	6	15	10	3.40	.61	2.1	.59		6 Independent
	MISSING	***	321	68*	.01	.13		.26		
16	1	1	18	10	-3.30	.40	.9	-.48	QVID1_UB_Dressing	1 Dependent
	2	2	33	18	-1.59	.08	.5	-.28		2 Maximum assistance
	3	3	33	18	-1.10	.10	.6	-.17		3 Moderate assistance
	4	4	29	16	-.30	.11	.5	.02		4 Supervision
	5	5	38	21	.12	.11	.7	.14		5 Setup
	6	6	32	17	2.44	.37	.8	.66		6 Independent
	MISSING	***	286	61*	-.47	.17		-.01		
17	1	1	20	12	-2.62	.33	.6	-.45	QVID2_Shower_Bath	1 Dependent
	2	2	47	29	-1.21	.09	.5	-.29		2 Maximum assistance
	3	3	40	25	-.38	.10	.7	.00		3 Moderate assistance
	4	4	25	16	.08	.11	.4	.10		4 Supervision
	5	5	16	10	.88	.39	2.7	.22		5 Setup
	6	6	13	8	3.82	.64	.8	.66		6 Independent
	MISSING	***	308	66*	-.49	.16		-.02		
18	1	1	20	25	-1.72	.45	2.4	-.49	QVID3_Pick_Up_Object	1 Dependent
	2	2	3	4	-.64	.23	.7	-.07		2 Maximum assistance
	3	3	11	14	-.08	.36	2.4	-.04		3 Moderate assistance
	4	4	11	14	.48	.27	1.1	.05		4 Supervision
	5	5	29	36	.48	.25	3.7	.10		5 Setup
	6	6	6	8	5.33	.72	.2	.66		6 Independent
	MISSING	***	389	83*	-.58	.13		-.11		

(continued)

Table 5-23 (continued)
Self-care+IADL distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	%	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
21	1	1	14	8	-2.90	.57	1.2	-.48	QVIE1_LB_Dressing	1 Dependent
	2	2	21	12	-.99	.22	1.0	-.29		2 Maximum assistance
	3	3	28	17	-.11	.20	1.9	-.17		3 Moderate assistance
	4	4	45	27	.50	.10	.7	-.08		4 Supervision
	5	5	20	12	1.36	.19	.6	.09		5 Setup
	6	6	41	24	3.64	.30	2.1	.69		6 Independent
	MISSING	***	300	64*	-1.16	.14		-.37		
36	1	1	3	38	-.33	1.03	2.7	-.37	QVIF10_Meds_Injectable	1 Dependent
	2	2	3	38	-.84*	1.05	3.5	-.47		2 Maximum assistance
	4	4	2	25	8.14	.02	.0	.95		4 Independent
	MISSING	***	461	98*	-.48	.12		-.11		
27	1	1	6	19	.64	.64	1.7	-.38	QVIF1_Laundry	1 Dependent
	2	2	8	26	1.22	.39	1.0	-.33		2 Maximum assistance
	3	3	9	29	2.36	.73	4.6	-.08		3 Minimal assistance
	4	4	8	26	6.00	.57	.8	.76		4 Independent
	MISSING	***	438	93*	-.67	.11		-.33		
28	1	1	2	6	-1.26	.78	.9	-.39	QVIF2_Make_light_meal	1 Dependent
	2	2	4	12	.44	.56	.7	-.33		2 Maximum assistance
	3	3	11	32	1.50	.36	1.0	-.33		3 Minimal assistance
	4	4	17	50	4.47	.52	1.1	.71		4 Independent
	MISSING	***	435	93*	-.70	.11		-.35		
29	1	1	3	9	.55	1.30	4.0	-.26	QVIF3_Dishwashing_hand	1 Dependent
	2	2	5	16	.25*	.46	.5	-.39		2 Maximum assistance
	3	3	9	28	1.68	.13	.1	-.22		3 Minimal assistance
	4	4	15	47	4.33	.70	3.4	.63		4 Independent
	MISSING	***	437	93*	-.67	.11		-.33		

(continued)

Table 5-23 (continued)
Self-care+IADL distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	DATA %	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
30	1	1	1	4	-2.04		.2	-.37	QVIF4_Dishwashing_machine	1 Dependent
	2	2	5	19	.82	.55	1.0	-.38		2 Maximum assistance
	3	3	8	31	1.60	.44	1.0	-.33		3 Minimal assistance
	4	4	12	46	5.07	.62	1.2	.75		4 Independent
	MISSING	***	443	94*	-.65	.11		-.32		
31	1	1	1	3	-2.04		.7	-.33	QVIF5_Wipe_surface	1 Dependent
	2	2	1	3	-1.21		.1	-.27		2 Maximum assistance
	3	3	8	24	.71	.43	.5	-.44		3 Minimal assistance
	4	4	23	70	3.75	.47	.8	.63		4 Independent
	MISSING	***	436	93*	-.69	.11		-.34		
32	1	1	1	2	-.14		3.6	-.13	QVIF6_Telephone_Answer	1 Dependent
	2	2	2	5	-1.83*	.62	.5	-.33		2 Maximum assistance
	3	3	3	7	.64	.72	1.6	-.14		3 Minimal assistance
	4	4	37	86	2.37	.43	1.5	.36		4 Independent
	MISSING	***	426	91*	-.70	.12		-.31		
33	2	2	2	5	-1.83	.62	.8	-.34	QVIF7_Telephone_make_call	2 Maximum assistance
	3	3	1	2	1.56		3.8	-.03		3 Minimal assistance
	4	4	38	93	2.32	.42	1.2	.30		4 Independent
	MISSING	***	428	91*	-.69	.11		-.31		
34	1	1	2	6	-.73	.25	1.9	-.27	QVIF8_Meds_Oral	1 Dependent
	2	2	4	11	-1.62*	.38	.2	-.51		2 Maximum assistance
	3	3	6	17	.78	.50	.6	-.24		3 Minimal assistance
	4	4	23	66	3.44	.47	.9	.66		4 Independent
	MISSING	***	434	93*	-.66	.11		-.30		
35	2	2	3	18	-1.48	.51	.2	-.56	QVIF9_Meds_Inhaled	2 Maximum assistance
	3	3	5	29	.72	.31	.3	-.27		3 Minimal assistance
	4	4	9	53	3.66	.92	.6	.67		4 Independent
	MISSING	***	452	96*	-.54	.12		-.18		

(continued)

Table 5-23 (continued)
Self-care+IADL distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	%	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
38	1	1	3	19	-1.88	2.09	1.6	-.63	QVIG2_Light_shopping	1 Dependent
	2	2	2	13	-.01	1.20	1.1	-.30		2 Maximum assistance
	3	3	4	25	2.91	.82	1.3	.00		3 Minimal assistance
	4	4	7	44	5.74	.88	1.5	.69		4 Independent
	MISSING	***	453	97*	-.57	.11		-.25		
40	2	2	1	13	-1.21		.2	-.67	QVIG4_Public_Transport	2 Maximum assistance
	3	3	2	25	3.90	.05	1.9	-.10		3 Minimal assistance
	4	4	5	63	5.85	1.43	3.9	.55		4 Independent
	MISSING	***	461	98*	-.53	.11		-.26		
41	1	1	2	33	2.52	1.40	3.3	-.41	QVIG5_Drive_a_car	1 Dependent
	2	2	1	17	-1.21*		10.0	-.71		2 Maximum assistance
	4	4	3	50	8.07	.07	.0	.92		4 Independent
	MISSING	***	463	99*	-.51	.11		-.23		

Table 5-24
Mobility scale distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	%	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
8	1	1	22	6	-4.77	.47	2.3	-.47	QVIB5_Sit_to_Stand	1 Dependent
	2	2	40	11	-2.67	.14	.5	-.41		2 Maximum assistance
	3	3	55	16	-1.01	.13	.6	-.25		3 Moderate assistance
	4	4	122	35	.64	.07	.5	-.03		4 Supervision
	5	5	23	7	1.99	.19	.4	.11		5 Setup
	6	6	86	25	4.77	.18	.5	.75		6 Independent
	MISSING	***	121	26*	-4.08	.31		-.56		
9	1	1	30	8	-5.50	.29	.8	-.53	QVIB6_Ly_to_Sit	1 Dependent
	2	2	52	14	-2.87	.16	.8	-.40		2 Maximum assistance
	3	3	71	19	-.63	.14	1.2	-.15		3 Moderate assistance
	4	4	74	20	.30	.11	.6	-.01		4 Supervision
	5	5	39	11	1.65	.17	.8	.13		5 Setup
	6	6	100	27	4.09	.22	2.1	.69		6 Independent
	MISSING	***	103	22*	-3.49	.40		-.42		
11	1	1	17	27	-4.03	.50	2.2	-.59	QVIB8_Wheel_50ft	1 Dependent
	2	2	9	14	-2.96	.35	.8	-.24		2 Maximum assistance
	3	3	7	11	-1.52	.70	2.1	-.03		3 Moderate assistance
	4	4	15	23	-.29	.30	.7	.20		4 Supervision
	5	5	5	8	.80	.84	1.8	.22		5 Setup
	6	6	11	17	2.11	.66	3.3	.56		6 Independent
	MISSING	***	405	86*	-.29	.19		.09		
12	1	1	14	19	-4.36	.57	2.7	-.53	QVIB9_Wheel_in_Room	1 Dependent
	2	2	7	10	-3.30	.40	.8	-.23		2 Maximum assistance
	3	3	17	23	-2.06	.25	.9	-.14		3 Moderate assistance
	4	4	14	19	-.79	.42	1.8	.09		4 Supervision
	5	5	9	12	.19	.56	1.4	.20		5 Setup
	6	6	12	16	2.63	.64	2.6	.63		6 Independent
	MISSING	***	396	84*	-.26	.20		.10		

(continued)

Table 5-24 (continued)
Mobility scale distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	DATA %	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
8	1	1	22	6	-4.77	.47	2.3	-.47	QVIB5_Sit_to_Stand	1 Dependent
	2	2	40	11	-2.67	.14	.5	-.41		2 Maximum assistance
	3	3	55	16	-1.01	.13	.6	-.25		3 Moderate assistance
	4	4	122	35	.64	.07	.5	-.03		4 Supervision
	5	5	23	7	1.99	.19	.4	.11		5 Setup
	6	6	86	25	4.77	.18	.5	.75		6 Independent
	MISSING	***	121	26*	-4.08	.31		-.56		
9	1	1	30	8	-5.50	.29	.8	-.53	QVIB6_Ly_to_Sit	1 Dependent
	2	2	52	14	-2.87	.16	.8	-.40		2 Maximum assistance
	3	3	71	19	-.63	.14	1.2	-.15		3 Moderate assistance
	4	4	74	20	.30	.11	.6	-.01		4 Supervision
	5	5	39	11	1.65	.17	.8	.13		5 Setup
	6	6	100	27	4.09	.22	2.1	.69		6 Independent
	MISSING	***	103	22*	-3.49	.40		-.42		
11	1	1	17	27	-4.03	.50	2.2	-.59	QVIB8_Wheel_50ft	1 Dependent
	2	2	9	14	-2.96	.35	.8	-.24		2 Maximum assistance
	3	3	7	11	-1.52	.70	2.1	-.03		3 Moderate assistance
	4	4	15	23	-.29	.30	.7	.20		4 Supervision
	5	5	5	8	.80	.84	1.8	.22		5 Setup
	6	6	11	17	2.11	.66	3.3	.56		6 Independent
	MISSING	***	405	86*	-.29	.19		.09		
12	1	1	14	19	-4.36	.57	2.7	-.53	QVIB9_Wheel_in_Room	1 Dependent
	2	2	7	10	-3.30	.40	.8	-.23		2 Maximum assistance
	3	3	17	23	-2.06	.25	.9	-.14		3 Moderate assistance
	4	4	14	19	-.79	.42	1.8	.09		4 Supervision
	5	5	9	12	.19	.56	1.4	.20		5 Setup
	6	6	12	16	2.63	.64	2.6	.63		6 Independent
	MISSING	***	396	84*	-.26	.20		.10		

(continued)

Table 5-24 (continued)
Mobility scale distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	%	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
14	1	1	47	31	-5.67	.21	1.7	-.71	QVIC2_Sit_to_Lying	1 Dependent
	2	2	33	22	-3.12	.18	.8	-.17		2 Maximum assistance
	3	3	20	13	-1.24	.19	.5	.09		3 Moderate assistance
	4	4	19	13	-.13	.22	.5	.21		4 Supervision
	5	5	6	4	1.28	.45	.8	.20		5 Setup
	6	6	26	17	3.19	.40	1.7	.69		6 Independent
	MISSING	***	318	68*	.35	.21		.30		
15	1	1	73	40	-6.19	.07	1.2	-.76	QVIC3_Roll_L_or_R	1 Dependent
	2	2	34	19	-3.63	.20	1.7	-.10		2 Maximum assistance
	3	3	15	8	-2.27	.28	1.3	.05		3 Moderate assistance
	4	4	24	13	-.25	.20	1.0	.30		4 Supervision
	5	5	5	3	-.08	.40	.6	.14		5 Setup
	6	6	31	17	2.74	.39	1.0	.73		6 Independent
	MISSING	***	287	61*	1.19	.17		.53		
19	1	1	6	10	-2.63	1.32	5.3	-.37	QVID4_Step_Curb	1 Dependent
	2	2	5	8	-.31	.90	3.6	-.10		2 Maximum assistance
	3	3	11	18	-.58*	.31	1.1	-.20		3 Moderate assistance
	4	4	14	23	.95	.44	4.3	.06		4 Supervision
	5	5	17	28	.08*	.47	3.5	-.12		5 Setup
	6	6	8	13	6.05	.63	.6	.72		6 Independent
	MISSING	***	408	87*	-.59	.19		-.11		
20	1	1	11	61	-3.01	.42	1.5	-.78	QVID5_Short_Ramp	1 Dependent
	3	3	1	6	.09		.2	.07		3 Moderate assistance
	5	5	2	11	-.32*	.59	3.2	.05		5 Setup
	6	6	4	22	4.61	1.42	3.1	.84		6 Independent
	MISSING	***	451	96*	-.41	.18		.02		

(continued)

Table 5-24 (continued)
Mobility scale distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	DATA %	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
22	1	1	2	3	1.42	.85	3.3	-.17	QVIE2_12_Steps_Interior	1 Dependent
	2	2	1	2	-.60*		.1	-.24		2 Maximum assistance
	3	3	3	5	.78*	.74	.8	-.28		3 Moderate assistance
	4	4	16	28	2.52	.31	1.3	-.26		4 Supervision
	5	5	22	38	2.85	.33	2.0	-.21		5 Setup
	6	6	14	24	6.68	.22	.0	.80		6 Independent
	MISSING	***	411	88*	-.99	.18		-.39		
23	2	2	1	1	-.60		.2	-.18	QVIE3_4_Steps_Interior	2 Maximum assistance
	3	3	6	7	1.31	.38	1.3	-.22		3 Moderate assistance
	4	4	39	45	1.81	.18	1.0	-.52		4 Supervision
	5	5	18	21	2.82	.34	1.5	-.05		5 Setup
	6	6	22	26	6.04	.24	.3	.81		6 Independent
	MISSING	***	383	82*	-1.22	.19		-.44		
24	1	1	2	2	-.01	.59	1.4	-.17	QVIE4_Walk_Long_dist_inside	1 Dependent
	2	2	1	1	2.06		2.3	-.03		2 Maximum assistance
	3	3	5	5	.52*	.57	.9	-.22		3 Moderate assistance
	4	4	48	44	1.24*	.13	.8	-.59		4 Supervision
	5	5	17	15	2.49	.30	.9	-.04		5 Setup
	6	6	37	34	5.14	.26	.5	.80		6 Independent
	MISSING	***	359	77*	-1.41	.19		-.47		
25	1	1	3	23	-3.89	2.26	1.1	-.74	QVIE5_Wheel_long_dist_inside	1 Dependent
	4	4	3	23	.12	.38	.2	-.06		4 Supervision
	5	5	2	15	1.15	.91	.7	.09		5 Setup
	6	6	5	38	3.03	.71	.9	.63		6 Independent
	MISSING	***	456	97*	-.46	.18		-.04		
26	1	1	1	20	-6.65			-.08	QVIE6_Long_ramp_exterior	1 Dependent
	6	6	4	80	3.44	.74		.10		6 Independent
	MISSING	***	464	99*	-.45	.18		-.05		

(continued)

Table 5-24 (continued)
Mobility scale distractor table

ENTRY NUMBER	DATA CODE	SCORE VALUE	DATA COUNT	%	AVERAGE MEASURE	S.E. MEAN	OUTF MNSQ	PTMEA CORR.	ACTVTY	
37	2	2	2	12	1.65	2.25	3.9	-.45	QVIG1_Get_in_out_car	2 Maximum assistance
	3	3	5	29	2.59	.98	1.3	-.61		3 Minimal assistance
	4	4	10	59	7.63	.35	.9	.86		4 Independent
	MISSING	***	452	96*	-.65	.17		-.31		
39	2	2	2	14	.30	.90	.3	-.84	QVIG3_Walk_a_block	2 Maximum assistance
	3	3	3	21	5.25	.70	.6	-.15		3 Minimal assistance
	4	4	9	64	7.64	.47	2.6	.74		4 Independent
	MISSING	***	455	97*	-.63	.17		-.31		
42	3	3	1	100	5.52		1.0	.00	QVIG6_Wheel_a_block	3 Minimal assistance
	MISSING	***	468	100*	-.44	.17		-.07		

Table 5-25
Self-care+IADL item table (all items)

ENTRY NUMBER	RAW SCORE	COUNT	MEASURE	REAL S.E.	INFIT MNSQ	INFIT ZSTD	OUTFIT MNSQ	OUTFIT ZSTD	PTMEA CORR.	ACTVTY	G
41	4	3	5.12	2.34	3.12	1.6	9.90	4.9	.81	QVIG5_Drive_a_car	B
27	57	25	2.24	.39	1.59	1.9	2.74	3.9	.73	QVIF1_Laundry	B
36	9	6	2.03	1.09	1.92	1.3	3.36	1.9	.86	QVIF10_Meds_Injectable	B
38	26	10	1.62	.60	1.40	1.0	1.33	.8	.82	QVIG2_Light_shopping	B
30	59	20	.65	.37	1.06	.3	.99	.1	.76	QVIF4_Dishwashing_machine	B
29	64	23	.63	.46	2.15	3.2	2.34	3.4	.55	QVIF3_Dishwashing_hand	B
40	16	5	.46	1.23	2.09	1.4	2.45	1.5	.69	QVIG4_Public_Transport	B
28	83	27	.32	.33	1.07	.3	.94	-.1	.72	QVIF2_Make_light_meal	B
21	528	141	.16	.09	1.03	.3	1.25	1.9	.81	QVIE1_LB_Dressing	A
46	92	31	.08	.38	3.47	5.9	2.89	4.4	.72	QVIA4_Tube_Feeding	A
18	257	73	.08	.19	2.30	5.9	2.68	6.8	.62	QVID3_Pick_Up_Object	A
17	459	153	.06	.08	.72	-2.7	.84	-1.4	.79	QVID2_Shower_Bath	A
43	1132	335	-.04	.06	.74	-3.6	.71	-3.8	.84	QVIA1_Toilet_Hygiene	A
13	322	106	-.15	.10	.97	-.2	.92	-.5	.86	QVIC1_Sponge_Bath	A
16	632	169	-.71	.08	.66	-3.6	.69	-3.1	.79	QVID1_UB_Dressing	A
34	96	29	-.88	.35	1.12	.5	.80	-.3	.67	QVIF8_Meds_Oral	B
35	49	15	-.89	.44	.40	-1.9	.36	-1.2	.72	QVIF9_Meds_Inhaled	B
31	91	26	-1.06	.38	.80	-.5	.64	-.5	.65	QVIF5_Wipe_surface	B
44	1620	349	-1.64	.07	.74	-3.3	.70	-3.4	.83	QVIA2_Oral_Hygiene	A
45	1695	339	-2.21	.08	1.22	2.3	1.05	.4	.76	QVIA3_Eating	A
32	114	31	-2.33	.58	2.07	2.5	1.38	.7	.39	QVIF6_Telephone_Answer	B
33	131	34	-3.54	.66	1.60	1.3	1.22	.6	.33	QVIF7_Telephone_make_call	B

Table 5-26
Mobility item table (all items)

ENTRY NUMBER	RAW SCORE	COUNT	MEASURE	REAL S.E.	INFIT MNSQ	INFIT ZSTD	OUTFIT MNSQ	OUTFIT ZSTD	PTMEA CORR.	ACTVTY	G
42	3	1	4.62	2.36	.00	-1.6	.00	-1.6	.00	QVIG6_Wheel_a_block	B
39	17	6	3.48	1.07	1.29	.6	1.26	.6	.89	QVIG3_Walk_a_block	B
37	27	9	2.40	.78	1.29	.9	1.33	.9	.82	QVIG1_Get_in_out_car	B
22	193	45	.63	.27	1.82	3.2	1.86	3.0	.69	QVIE2_12_Steps_Interior	A
23	296	69	.32	.16	.87	-.7	.85	-.8	.81	QVIE3_4_Steps_Interior	A
20	41	16	.08	.55	2.42	2.9	1.85	1.6	.84	QVID5_Short_Ramp	A
24	410	92	-.24	.15	1.02	.2	.96	-.2	.77	QVIE4_Walk_Long_dist_inside	A
4	810	207	-.32	.10	1.13	1.2	.97	-.2	.85	QVIB1_Walk_50ft	A
6	1019	282	-.43	.08	.81	-2.3	.76	-2.6	.90	QVIB3_Toilet_Transfer	A
7	1109	303	-.65	.08	.56	-6.3	.52	-6.0	.92	QVIB4_Chair_Transfer	A
5	986	249	-.65	.09	.65	-4.2	.59	-4.3	.89	QVIB2_Walk_in_Room	A
8	1125	297	-.73	.08	.57	-6.0	.55	-5.3	.91	QVIB5_Sit_to_Stand	A
19	195	53	-.76	.34	3.50	7.8	3.61	7.2	.60	QVID4_Step_Curb	A
9	1183	311	-1.01	.08	1.13	1.6	1.10	1.0	.88	QVIB6_Ly_to_Sit	A
14	359	115	-1.02	.13	.99	.0	.97	-.2	.91	QVIC2_Sit_to_Lying	A
11	197	59	-1.13	.24	1.94	4.3	1.80	3.2	.80	QVIB8_Wheel_50ft	A
25	53	11	-1.28	.70	2.64	2.6	2.29	1.5	.82	QVIE5_Wheel_long_dist_inside	A
12	236	67	-1.62	.21	1.71	3.5	1.77	3.0	.81	QVIB9_Wheel_in_Room	A
15	373	107	-1.69	.13	.94	-.4	.94	-.3	.93	QVIC3_Roll_L_or_R	A
26	24	4	-2.76	1.76	MINIMUM ESTIMATED MEASURE					QVIE6_Long_ramp_exterior	A

5.3.5 Stability of Hierarchy: Reliability

We are also concerned with the stability of this item hierarchy for all patients. That is, is the ordering of items from hard to easy the same, regardless of whether you are assessing a very

able or a very disabled patient? Infit statistics provide an indication of how well the item hierarchy is performing. Infit mean squares are a chi-square statistic that reflects how expected the responses were for that item, weighted for how close the item is to the patient's level of ability. For example, is it not unexpected for a very able patient to score 5 or 6 on the item "walk a block." It would be much unexpected for a very disabled patient to score 5 or 6 on this item. It would not be unexpected for a very disabled person to score 5 on an easy item such as sit to lying. Infit values close to 1.00, indicate the item is operating as expected. Generally, infit statistics above 1.4 are considered misfitting. These items are underlined in ***Tables 5-25 and 5-26***. Generally, high infit statistics indicate that the item is not operating in the same way as others to define the construct, perhaps the items captures a different concept than other items. The general approach is to sequentially remove misfitting items from the analysis and examine the subsequent impact on item fit statistics, the separation index, and person reliability statistic. This process was completed for both the self-care+IADL and mobility scales. ***Tables 5-27 and 5-28*** present the results of this process and ***Tables 5-29 and 5-30*** and ***Figures 5-4 and 5-5*** present the final or best fitting item hierarchies. This process eliminates poorly operating and redundant items and retains items that provide the most information toward determining differences in patient functioning with the least loss of precision and range. For the self-care+IADL scale, removing misfitting and redundant items marginally increases the reliability of the scale. Even though the test has been shortened by 38 percent we have as much, and as precise, information about the range of function in these patients as with the longer test. This is because the items removed were not adding information to the detection of patient differences.

For the mobility scale, there is a different situation. Patients are administered different items depending on whether they use wheelchair or walking as their primary mode of transportation. All patients are administered transfer and bed mobility items but locomotion items vary by mode of locomotion. When all items are analyzed together, it was generally the wheelchair items that misfit. Removing these items does not change the patient reliability value at all. Another way to examine the item structure is to analyze the data only for patients with wheelchair as the primary mode and then only for patients with walking as the primary mode. The item difficulties for the common mobility items are presented in ***Figure 5-6***. Comparing the item difficulties for the common items from these two analyses suggests that mobility may not be the same concept for these two groups of patients. That is, even these common items are not ordered in the same way for these two groups of patients.

Table 5-27
Self-care scale psychometrics (removing each misfit sequentially)

Items	Mean measure	Error	RMSE	Adj. SD	Separation	Patient rel.
All Items	-.24	.61	.64	1.36	2.12	.82
Deleted Items						
Tubefeeding	-.28	.63	.66	1.43	2.17	.82
Drive Car	-.02	.63	.66	1.44	2.18	.83
Dishwashing - hand	.05	.63	.67	1.46	2.19	.83
Public Transport	.09	.64	.67	1.48	2.21	.83
Answer Phone	-.04	.64	.68	1.51	2.24	.83
Injectable Meds	.12	.64	.68	1.53	2.25	.83
Inhaled Meds	.07	.64	.68	1.52	2.24	.83
Pick up objects	.05	.68	.72	1.64	2.29	.84
Light shopping	.19	.68	.71	1.58	2.22	.83

Table 5-28
Mobility scale psychometrics (removing each misfit sequentially)

Items	Mean measure	Error	RMSE	Adj. SD	Separation	Patient rel.
All Items	.42	.74	.78	2.34	3.01	.90
Deleted Items						
Wheelchair Walkers only	.94	.78	.83	2.25	2.72	.88
Walking Chair users	-1.12	.75	.79	2.01	2.54	.87

NOTE: Core items were used as item anchors in subsequent walking and wheelchair analyses, walking items calculated on patients whose primary mode of locomotion is walking, and wheelchair items calculated only on patients whose primary mode of locomotion is wheelchair.

Table 5-29
Self-care psychometrics

ENTRY NUMBER	RAW SCORE	COUNT	MEASURE	REAL S.E.	INFIT MNSQ	INFIT ZSTD	PTMEA CORR.	ACTVTY	G
27	57	25	3.34	.47	1.90	2.7	.71	QVIF1_Laundry	B
38	26	10	2.47	.82	2.10	2.0	.81	QVIG2_Light_shopping	B
30	59	20	1.39	.51	1.60	1.6	.76	QVIF4_Dishwashing_machine	B
28	83	27	.94	.43	1.46	1.5	.75	QVIF2_Make_light_meal	B
21	521	139	.55	.10	1.15	1.2	.83	QVIE1_LB_Dressing	A
17	446	150	.43	.09	.82	-1.6	.82	QVID2_Shower_Bath	A
43	1119	332	.30	.06	.86	-1.9	.86	QVIA1_Toilet_Hygiene	A
13	321	105	.15	.12	1.10	.7	.88	QVIC1_Sponge_Bath	A
16	619	166	-.51	.09	.75	-2.5	.81	QVID1_UB_Dressing	A
34	96	29	-.58	.42	1.30	1.1	.73	QVIF8_Meds_Oral	B
31	91	26	-.75	.42	.98	.0	.71	QVIF5_Wipe_surface	B
44	1607	346	-1.59	.07	.78	-2.8	.85	QVIA2_Oral_Hygiene	A
45	1683	337	-2.25	.09	1.36	3.7	.77	QVIA3_Eating	A
33	131	34	-3.90	.79	1.91	1.7	.37	QVIF7_Telephone_make_call	B

Table 5-30
Final items for walkers and wheelchair users

ENTRY NUMBER	RAW SCORE	COUNT	MEASURE	REAL S.E.	INFIT MNSQ	INFIT ZSTD	PTMEA CORR.	ACTVTY	G
39	17	6	5.74	1.19	1.39	.8	.88	QVIG3_Walk_a_block	B
37	24	8	3.78A	.92	1.43	1.2	.83	QVIG1_Get_in_out_car	B
20	29	13	.82	.71	2.68	3.0	.85	QVID5_Short_Ramp	A
22	145	35	.78	.57	3.40	5.5	.52	QVIE2_12_Steps_Interior	A
23	218	53	.65	.27	1.22	1.0	.70	QVIE3_4_Steps_Interior	A
6	719	195	.27A	.11	.91	-.8	.82	QVIB3_Toilet_Transfer	A
4	633	166	.11	.16	1.60	4.1	.72	QVIB1_Walk_50ft	A
24	304	72	.04	.27	1.38	1.7	.68	QVIE4_Walk_Long_dist_inside	A
7	760	202	-.18A	.11	.49	-5.6	.88	QVIB4_Chair_Transfer	A
8	790	205	-.30A	.12	.52	-5.2	.86	QVIB5_Sit_to_Stand	A
19	156	42	-.43	.48	3.69	6.7	.55	QVID4_Step_Curb	A
5	744	188	-.46	.13	.77	-2.0	.79	QVIB2_Walk_in_Room	A
14	223	72	-.71A	.21	1.27	1.4	.88	QVIC2_Sit_to_Lying	A
11	144	48	-.74	.29	1.92	3.6	.79	QVIB8_Wheel_50ft	A
9	790	211	-.76A	.13	1.23	1.9	.83	QVIB6_Ly_to_Sit	A
26	15	3	-1.23	1.89	----	---	----	QVIE6_Long_ramp_exterior	A
25	32	7	-1.27	.70	.23	-1.6	.95	QVIE5_Wheel_long_dist_inside	A
12	192	57	-1.59	.24	1.47	2.2	.82	QVIB9_Wheel_in_Room	A
15	244	71	-2.10A	.20	1.19	1.1	.90	QVIC3_Roll_L_or_R	A

NOTE: Core items (indicated by letter “A” in Measure column) calculated on all patients, walking items calculated on patients whose primary mode of locomotion is walking, and wheelchair items calculated only on patients whose primary mode of locomotion is wheelchair.

Figure 5-4
Self-care (final items)

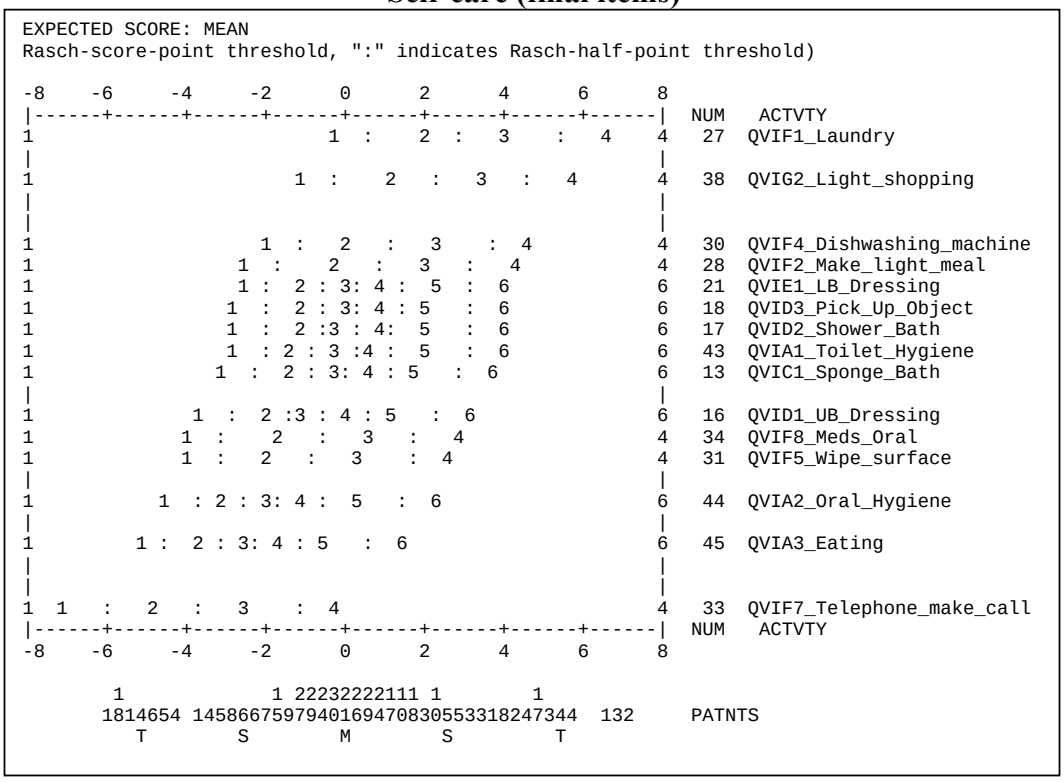


Figure 5-5
Mobility (final items)

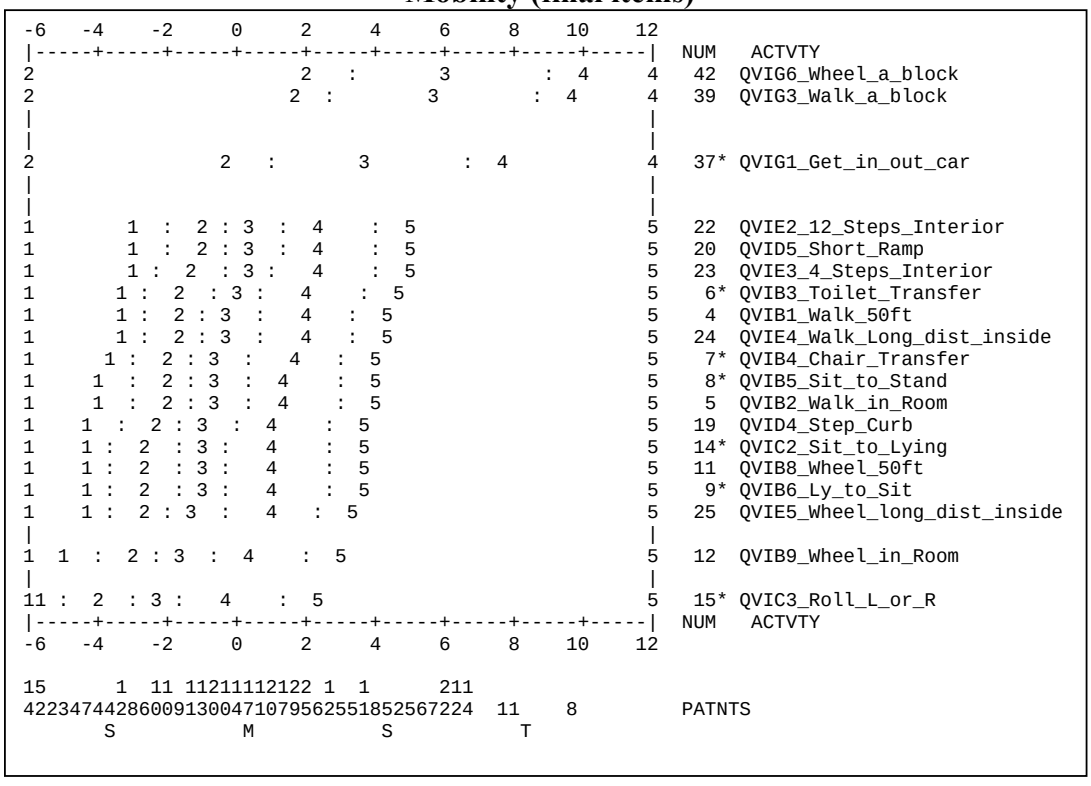
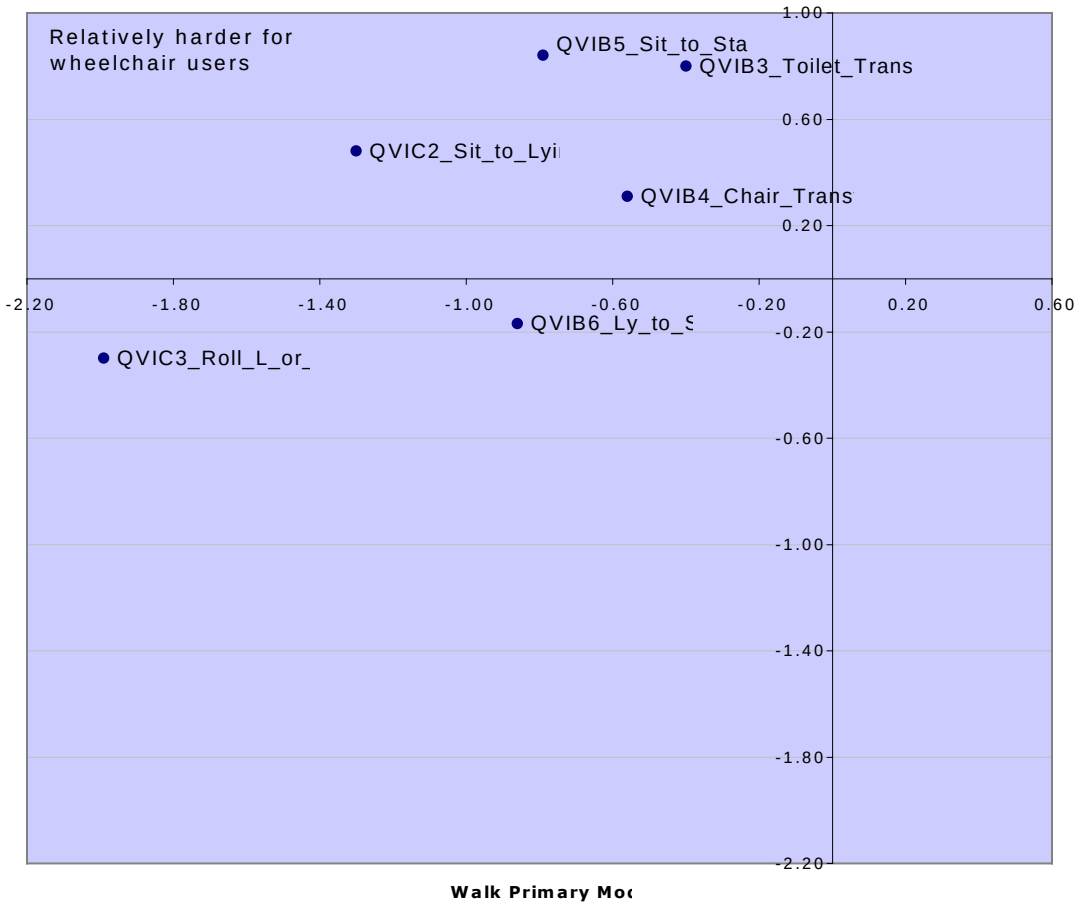


Figure 5-6
Mobility item comparison scatterplot



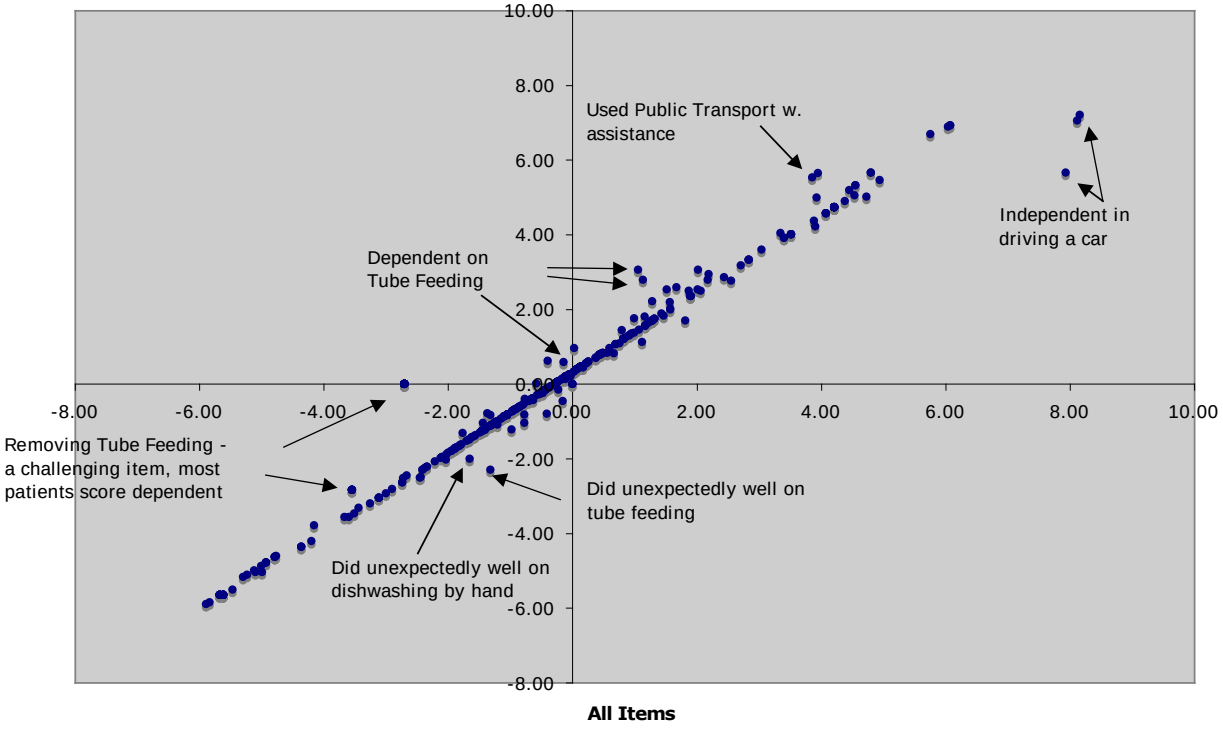
In the process of these analyses, misfitting patient responses were uncovered. Clinicians were instructed to score the patient on their primary mode of locomotion. However, some patients received low scores (1) on easy wheelchair items while receiving independent scores on very challenging walking items. This pattern was particularly prevalent for one facility. It may be that current IRF scoring practices (scoring 1 if the item were not observed) were inadvertently applied to these data.

Overall, given how few patients were administered the mobility items during the pilot, it is too early to conclude wheelchair items do not align with the mobility construct or that mobility as defined by wheelchair users differs from the construct as defined by patients who walk. Further data collection on a larger range of patients is needed before determining the final structure of the mobility scale.

It is also important to examine the impact of items on patient ability measures. That is, what impact does the removal of items have on how able or impaired we would estimate a patient to be? ***Figure 5-7*** presents patient self-care+IADL measures when measured with the full scale (all items) and when measured with the "final" or "best" set of items. Removal of the nine

items has almost no effect—patients' measures essentially form an identity line. The figure is marked to describe those patients that lie away from the identity line. In almost all cases, patient measures are different because of the removal of the "tube feeding" item. Yet the impact is not always in the same direction, that is, for some patients their measure was lower, for some higher. This suggests that tube feeding, while an important item to capture in terms of resource utilization, is fundamentally different that other patient function items.

Figure 5-7
Comparison of person measures on self-care_all and self-care final



5.3.6 Principal Component Analyses

Rasch analysis assumes that the construct being measured is unidimensional, that is, that the items all relate to the same construct. In the case of the CARE instrument, the constructs are Self-care+IADL and mobility. ***Tables 5-31 and 5-32*** present the results of a principal components contrast analysis for the two subscales. These results indicate that there are no substantial subdimensions to these scales.

Table 5-31
Self-care+IADL principal contrast table

CON-TRAST	LOADING	INFIT MEASURE	INFIT MNSQ	OUTFIT MNSQ	ENTRY NUMBER	ACTVTY	GROUP
1	.87	.79	1.43	1.22	A 28	QVIF2_Make_light_meal	B
1	.70	-.82	.96	.70	B 31	QVIF5_Wipe_surface	B
1	.68	3.05	1.71	4.40	C 27	QVIF1_Laundry	B
1	.57	-.64	1.29	.94	D 34	QVIF8_Meds_Oral	B
1	.33	1.22	1.42	1.27	E 30	QVIF4_Dishwashing_machine	B
1	.08	-3.72	1.90	1.64	F 33	QVIF7_Telephone_make_call	B
1	.01	.45	2.44	2.74	G 18	QVID3_Pick_Up_Object	A
1	-.27	.16	.99	.92	a 13	QVIC1_Sponge_Bath	A
1	-.19	-1.43	.76	.72	b 44	QVIA2_Oral_Hygiene	A
1	-.17	.53	1.09	1.31	c 21	QVIE1_LB_Dressing	A
1	-.17	.40	.74	.85	d 17	QVID2_Shower_Bath	A
1	-.07	.30	.79	.75	e 43	QVIA1_Toilet_Hygiene	A
1	-.04	2.21	1.74	1.80	f 38	QVIG2_Light_shopping	B
1	-.03	-.44	.70	.72	g 16	QVID1_UB_Dressing	A
1	-.01	-2.05	1.32	1.11	H 45	QVIA3_Eating	A

Table of STANDARDIZED RESIDUAL variance (in Eigenvalue units)

	Empirical		Modeled	
Total variance in observations =	222.4	100.0%		100.0%
Variance explained by measures =	207.4	93.3%		93.4%
Unexplained variance (total) =	15.0	6.7%	100.0%	6.6%
Unexplned variance in 1st contrast =	2.3	1.0%	15.5%	

Table 5-32
Mobility principal contrast table (walking items)

CON-TRAST	LOADING	INFIT MEASURE	INFIT MNSQ	OUTFIT MNSQ	ENTRY NUMBER	ACTVTY	GROUP
1	.70	-.13	.60	.57	A 7	QVIB4_Chair_Transfer	A
1	.67	-.47	.58	.53	B 8	QVIB5_Sit_to_Stand	A
1	.47	.20	.90	.83	C 6	QVIB3_Toilet_Transfer	A
1	.25	-.50	1.26	1.27	D 9	QVIB6_Ly_to_Sit	A
1	.12	4.47	1.32	1.22	E 39	QVIG3_Walk_a_block	B
1	-.53	1.23	2.02	2.17	a 22	QVIE2_12_Steps_Interior	A
1	-.48	.22	1.33	1.17	b 4	QVIB1_Walk_50ft	A
1	-.48	.90	.97	.95	c 23	QVIE3_4_Steps_Interior	A
1	-.45	.28	1.20	1.12	d 24	QVIE4_Walk_Long_dist_inside	A
1	-.29	-.17	.72	.66	e 5	QVIB2_Walk_in_Room	A
1	-.16	-.69	1.21	1.16	f 14	QVIC2_Sit_to_Lying	A
1	-.15	3.70	1.34	1.35	g 37	QVIG1_Get_in_out_car	B
1	-.10	-.13	3.99	3.78	G 19	QVID4_Step_Curb	A
1	-.05	-2.11	1.20	1.11	F 15	QVIC3_Roll_L_or_R	A

CONTRAST 1 FROM PRINCIPAL COMPONENT ANALYSIS OF
STANDARDIZED RESIDUAL CORRELATIONS FOR ACTVTYS (SORTED BY LOADING)

Table of STANDARDIZED RESIDUAL variance (in Eigenvalue units)

	Empirical		Modeled	
Total variance in observations =	100.7	100.0%		100.0%
Variance explained by measures =	86.7	86.1%		85.7%
Unexplained variance (total) =	14.0	13.9%	100.0%	14.3%
Unexplned variance in 1st contrast =	2.3	2.3%	16.6%	

5.3.7 Person Ability Measures—Targeting of Items to People

The mean patient measure for self-care+IADL items was .18 $\pm$ 2.86, suggesting the persons and items are well targeted (a perfectly targeted measure would have a mean of 0.0). In the final self-care+IADL analyses 43 (10 percent) patients had maximum scores and 43 (10 percent) patients had minimum scores. Maximum scores were most common in IRF admission and acute hospital discharge settings. Most of these patients were observed on only 3-4 items and were reported as independent on all items observed. These patients were generally not observed on the additional items, which provide more challenge, and this may have created a "false" ceiling. Minimum scores were most common in LTCH admission and acute hospital settings. Most of these patients were observed on only two to four items and were reported as dependent on all items observed. Because minimum scores were most often seen with patients in LTCH patients at admission, it may well be that function is not the best construct for distinguishing differences in need for these patients.

The mean mobility measure for walking patients was 1.52 $\pm$ 3.76 and for wheelchair patients was 1.78 $\pm$ 2.97. In the final mobility analyses 59 (18 percent) of walking patients and 2 (2 percent) of wheelchair patients had maximum scores and 27 (8 percent) of walking patients and 15 (16 percent) of wheelchair patients had minimum scores. Maximum scores for walking patients were most common in IRFs discharge and HHA settings. Most of these patients were administered six to eight items and were reported as independent in all of them. Minimum scores were most common in LTCH admission settings. Most patients were observed on only one or two items and reported as dependent on all of them.

5.3.8 Person Infit Values

Examining the person response patterns is also important for examining the quality of the function scales. For the self-care+IADL scale, 25 (6 percent) of patients had misfitting response strings. This implies that these patients did not respond to items close to their level of ability in a manner that would be expected by the model. For the mobility scale, 26 (8 percent) of walking patients and 16 (18 percent) of wheelchair patients had misfitting response strings. Inspection of misfitting patient response patterns revealed that these may be in large part due to erroneous scores. For example in one facility, raters appeared to be scoring items with a value of "1" when the items were not administered (a current IRF-PAI scoring practice).

Overall, it appears that the functional scales demonstrate construct validity and the constructs are stable across patients. It is clear that some facilities had difficulty selecting the appropriate level of supplemental items for patients, so that some patients were not provided items challenging enough to fully identify their functional status. In some cases we found that more items were answered for individual patients than were appropriate to their level of functioning. This, in effect, blunted the specificity of the instrument, resulting in less than fully identified functional status. This finding suggests that instructions, layout, and training on use of the instrument will require adjustments, rather than the selection of items. Although the current results are satisfactory, we believe they will be improved if the training and instructions review these areas carefully.

5.4 Time to Fill out the Form

Each domain of the CARE tool ended with an item asking for the amount of time it took to fill out that section of the tool. The amount of time taken to fill out the form was completed for up to half the records for some sections, and not at all for others. However, the time question was disproportionately filled out by respondents who skipped the section and therefore recorded zero minutes. There were not enough nonzero responses to analyze these data.

5.5 Summary of Pilot Instrument Performance

All settings demonstrated that it was feasible to answer all items in the CARE tool. The extent of missing items varied by site and specific item rather than by setting. The LTCH assessments had higher percent missing than other settings in all sections.

The initial sections, Administrative Items and Administrative Information, contained some of the most complete items (demographic and advance directive, durable power of attorney, and code status items) and also the least complete (personally identifying information and institutional billing numbers). Most items that were not personally identifying had fewer than 10 percent missing for each setting except LTCH. Of concern, items with fewer responses were education level, which was between 15 and 20 percent missing in each setting, and zip code and "prior lives with," which had high percent missing for AHs and LTCHs.

The Current Medical Items section items varied in response rate by setting. LTCHs were missing primary diagnoses at discharge in half of responses, on average, while all other settings were missing no more than 14 percent. Three settings had 100 percent response rates for discharges. The screening question for procedures was missing in 20 percent of responses from the clinically intensive sites, but 60 and 78 percent of SNF and HHA responses, respectively. Treatments were selected infrequently—the modal percent missing was 100 percent. Peritoneal dialysis, Halo, and Complex External Fixators were never selected. Medication names were reported with all available space used. Dose, frequency, and route were completed in the SNF, but less than half the time in other settings. The pressure ulcer risk and screening questions were missing in fewer than 10 percent of responses. More detailed pressure ulcer items were less frequently reported. The presence of wounds was unanswered in 37 percent of responses. The last subsection of Current Medical Items was Physiologic Factors. Response rates varied by factor, and not all factors pertain to all patients. Most factors were completed in at least 50 percent of responses. Factors with less than a 50 percent response rate were: HgA1c, prealbumin, pH, PaCo2, HCO3, PaO2, SaO2, Base Extract, and Left Ventricular Ejection Fraction.

The Cognitive Status, Impairments, and Functional Status items were directed to subsets of the entire respondent pool. Cognitive Status and Functional Status had complex skip patterns and less complete responses than other sections of the questionnaire. Respondents to items were not limited to the intended subpopulation. Impairments items were answered for all noncomatose patients and had better than 90 percent response rate. The frailty items applied to all respondents and also had better than 90 percent response rates, on average, for all settings. The general discharge items were completed for most patients, but the response rate varied for each item.

Overall, item response seems feasible in all settings. The items that applied to all patients had the highest response rates; items that contained complex skip patterns had lower response. More general items, such as medication name, were answered more often than more detailed items, such as medication dose, frequency, and route of administration. Evaluation of internal consistency, construct validity, and reliability indicate that the scales and constructs used work in the intended manner. It must be noted that in some settings our sample was quite low (e.g., discharge from HHA), so that the issue of reliability and validity needs to be revisited using the more robust data that will be obtained from the demonstration.

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SECTION 6
OMB COMMENTS AND RESULTING CHANGES TO CARE TOOL

The CARE tool (CMS Form Number 10243) was submitted for OMB review on July 17, 2007. RTI and CMS staff held several meetings to review, categorize, and discuss responses throughout and subsequent to the 60-day public comment period ending September 25, 2007. A total of 79 comments were received from individuals, physicians, nurses, occupational therapists, physical therapists, speech-language pathologists, social workers, case managers, hospitals, long-term care hospitals, critical access hospitals, nursing facilities, home health agencies, inpatient rehabilitation facilities, professional associations, health care organizations and associations, and family and caregiver associations. Prominent industry associations such as the American Hospital Association (AHA), American Medical Rehabilitation Providers Association (AMRPA), American Congress of Rehabilitation Medicine (ACRM), Association for the Advancement of Wound Care (AAWC), American Association of Retired Persons (AARP), National Association of Long Term Care Hospitals (NALTH), American College of Certified Wound Specialists, and Visiting Nurse Services of New York sent responses.

Overall, many positive comments were received from health care providers and professional associations, supporting the need for development of a consistent, standardized patient assessment instrument to collect data on patient characteristics, treatment needs, and outcomes. Many also applauded CMS' efforts to develop a tool aimed at improving beneficiaries' transitions between care settings, enhancing patient safety, and improving communication across the continuum of care.

Commenters requested clarification of terms and underscored the need to provide sufficient staff training. There were general concerns regarding provider burden, whether the CARE instrument adequately captured factors important to explaining placement decisions, including physician decision making processes. Some commenters related concerns that the CARE tool may affect beneficiaries' access to services and/or may be used to determine post-discharge placement of patients in particular level-of-care settings. Commenters also raised the issue that the CARE tool has a "one size fits all" approach that will lead to unrealistic expectations regarding its usefulness for clinical purposes, reimbursement, and outcomes analysis. RTI and CMS responses to these areas of concern addressed the plan for staff training and the development of the user's manual. This response also included further explanation about the tool's purpose of capturing data related to severity of illness and degree of impairment.The data are expected to be predictive of resource utilization and outcomes, and not to dictate treatment nor direct discharge placement. Finally, the CARE tool was designed with both core and supplemental items allowing for skip patterns with certain supplemental items addressing important subpopulations, such as those with pressure ulcers. The technology for automating the CARE tool, in modules, will facilitate revisions to the CARE tool.

CMS also received comments suggesting general changes and other comments recommending revisions, deletions, and additions to specific assessment items. Quite a few suggestions were for specific wording changes or requested clarification, many of which have been incorporated into the subsequent version of the CARE tool. The following paragraphs summarize changes made to the CARE tool, section by section, based on both public comments and internal project team review. Please refer to Table 4-1, "Revisions to CARE Tool Post

OMB" to review more detailed information regarding the changes to the CARE tool. The table provides a side by side comparison of the CARE tool as submitted to OMB and revised post the public comment period. It references the section of the CARE tool, item number, actual wording, and reason for change.

6.1 Item Changes

6.1.1 Signature

The attestation wording was revised to better reflect that the CARE tool information would be gathered as a part of a demonstration and the date field was revised to clarify the date of data collection.

6.1.2 Administrative Items

Administrative items were modified slightly to incorporate the patient's middle initial and name and to add a response option to the payment source item. Questions concerning English as the patient's primary language were revised to both clarify the need for an interpreter and collect data regarding the patient's primary language. Missing items were added; the assessment reference and expired date. The Advance Care directive item was deleted although this topic is addressed by items in Section VII: Overall Plan of Care/Advance Care Directives.

6.1.3 Admission Information

Response options were modified for the items addressing where the patient was admitted from, who they previously lived with, their prior functioning, and mobility devices and aids used prior to the current illness or injury. Minor wording changes were made to clarify the items pertaining to the patient's primary diagnosis treated in another medical setting, medical services used in the last two months, self-care option referring to prior functioning, and history of falls. A question was added addressing any assistance the patient utilized if the patient lived in the community prior to the current admission. Items for the primary diagnosis ICD-9-CM code and prior mental status were deleted.

6.1.4 Current Medical Items (Revised—Current Medical Information)

The section name was altered slightly. The diagnosis and procedure items were revised to reflect clinician input and clarify instructions; additional directives were added for home health agencies. The items addressing diagnoses and procedures were divided into two separate sections of the CARE tool to reduce provider burden and improve data accuracy. The first section identifies the primary diagnosis, other diagnoses, comorbidities, complications, and major procedures as reported by clinicians for continuity of care purposes, thus the ICD-9-CM code items in the manual form were deleted. A later section (Section IX) was added for coding professionals to identify the ICD-9 CM codes and related diagnosis labels. Items were added when collecting data from the clinicians for procedures to identify whether the procedure was performed on the right or left side (or both) or was not applicable. These changes resulted in numbering changes for that section.

The "Treatments" section was renamed "Major Treatments" for the purpose of clarification of the intent of completing this section. Directions for completing the frequency of

suctioning were revised and the items referring to complex dressing changes, specialty beds, IV vaso-actors, and external fecal management system were slightly reworded to be more specific. Items referencing urinary catheter, intermittent urinary catheterization, and colostomy were deleted to avoid duplication of data collection. A write in item for other major treatments was added in order to collect additional data for the demonstration that might result in changes to that section based upon demonstration findings.

Several items addressing pressure ulcers and wounds underwent minor revisions. Wording was revised to provide more detail regarding the options listed for the item concerning formal evaluation of the risk of pressure ulcer and turning surfaces as well as the definition of nonhealing surgical wound. Wording was added to help specify the type of "Other" nonhealing wound. Directions regarding number of pressure ulcers on assessment and measurement were modified for the purpose of clarification. Also, the definitions of Stage 3, 4, and unstageable pressure ulcers were reworded and the definition of Stage 2 was added to reflect industry standards.

Directions for the completion of items relating to physiologic factors were revised and additional directions were written to include information concerning whether a patient's arterial blood gases were tested when the patient was on supplemental oxygen. Also, pulmonary function tests were added to this section based on medical provider input.

6.1.5 Cognitive Status (Revised—Cognitive Status, Mood, and Pain)

The section title was reworded to reflect the items in the section addressing mood and pain. The vast majority of the changes in this section reflect a significant reduction of provider burden based on internal discussions and OMB comments. First, a brief explanation of how the Brief Interview for Mental Status (BIMS) is completed is required. There are two components of the BIMS; temporal orientation and patient recall. The patient is initially given three words to remember, next the temporal orientation questions are asked, and then the patient is asked to recall the three words. The CARE tool initially directed all providers to complete the BIMS on admission and discharge (unless the BIMS is not attempted and the clinician is then asked to indicate the reason the interview was not attempted). A decision was made that for acute care discharges, only the temporal questions will be asked that address the patient's orientation to year and month (for the BIMS, the temporal orientation questions address year, month, and day). The full BIMS will be completed only for post-acute care admissions.

Another change post-OMB public comment period is the observational assessment of cognitive status items will only be completed if the patient cannot be interviewed, and then only the memory/recall ability item will remain. The short-term memory, long-term memory, and cognitive skills for daily decision making items were deleted. Also, an additional option was added for the memory/recall ability item. The confusion assessment method item will be completed only if patients score poorly on the temporal questions or BIMS dependent on the health care setting (acute discharge versus post-acute care admission).

The items addressing behavioral signs and symptoms, mood, the Patient Health Questionnaire (PHQ2), and feeling sad will now be completed only for post-acute care admissions and discharges, not acute care discharges. The item referencing patient pain severity

providing response options from mild to severe was omitted to reduce provider burden given the item asking about pain severity and providing a scale of zero to ten. The item regarding pain effect on function was reworded slightly. The instructions for the pain observational assessment item were also modified to emphasize when the item should be completed. Due to the revisions to this section there were also renumbering and formatting changes.

6.1.6 Impairments

At the beginning of the Impairment section of the CARE tool submitted to OMB for review, there was one inclusive question asking if the patient had any impairments (bowel and bladder management, hearing, vision, communication, range of motion, weight-bearing, grip strength, respiratory status, or endurance). The skip pattern then directed the clinician to skip the entire section if the patient had none of the above listed impairments or complete all the items related to impairments if they had one of the impairments. The section was revised to be more logical and user friendly and to decrease burden by asking the clinician whether the patient had a specific, individual impairment and then directing them to skip those related items if the patient did not have that specific impairment. Subsequently, items were renumbered accordingly and response options in the items themselves indicating no impairment were removed.

There were also wording revisions to this section in order to be more accurate or clarify the items or options. The items related to bladder impairment were revised to more accurately address only bladder issues, not bowel and bladder. Additional response options were added to items addressing patient understanding verbal content and expression of wants and ideas to increase precision in the data collected for analysis. The respiratory status items were revised by adding options to identify whether the patient was/was not using supplemental oxygen and if the question was not applicable (patient comatose or on a ventilator). The upper extremity range of motion item was deleted based on both public response and internal discussions.

The endurance items addressing both mobility and sitting were revised and reworded to improve the quality and specificity of the data collected. Wording was revised for the item related to mobility endurance to better define the item and additional response options were added to indicate whether the patient needed rest. The sitting endurance item wording was revised and the timeframe was lengthened from three minutes to one hour and response items were added to capture data on whether the patient required support. Two additional response items were added to the "mobility devices and aids needed" item: "orthotics/prosthetics" and "none apply."

6.1.7 Functional Status (Revised—Functional Status: Usual Performance)

The majority of revisions focused on wording revisions in order to better clarify directions, items, or response options. The words "Usual Performance" were added to the section heading to better convey the goal for data collection, based on the patient's usual, not best performance over the assessment period. For the item addressing lower body dressing, the phrase "does not include footwear" was added. The response options for the items lying to sitting on the side of the bed, site to stand, chair/bed-to-chair transfer, and toilet transfer added the word "safely" to improve the quality of data captured and better reflect the intent of data collection. Directions for the items addressing the longest distance the patient walked or wheeled were revised and the words "at least" to the measurement options were added for

clarity. Directions for supplemental functional ability items were also revised to focus clinicians on patients requiring post-acute care and how to measure the patient's functional status. Coding options were added and modified for selected items. Several response options for the supplemental functional items were slightly reworded to increase precision such the addition of "with a rail" added to the option for the 12 steps-interior item and "goes up and down" for wheel short ramp item. For the supplemental functional ability items relating to telephone-answering to use of public transportation, the coding scale was increased from four to six (same scale used for all other core and supplemental items).

6.1.8 Engagement (Deleted Section)

The engagement item was deleted.

6.1.9 Frailty/Life Expectancy (Revised—VII. Overall Plan of Care/Advance Care Directives)

The section was renamed to better reflect the items in the section. Items addressing the expectation of whether the patient would be readmitted to the acute care hospital or expire were replaced with three new items; agreed-upon care goals, patient overall health status, and documented care decisions.

6.1.10 Discharge Status (Revised—VIII)

In the subsection A, discharge information, an item was added for the attending physician's name, and the options listed and skip pattern for the item discharge location were revised. An additional response option was added to the frequency of assistance at discharge to reflect whether the patient required no assistance, and the skip pattern was also revised. The item addressing caregiver availability at discharge was renamed to caregiver availability, moved to subsection B, reworded, and the skip pattern was altered. An item from subsection B, willing caregiver(s), was significantly revised. The item referencing types of caregiver(s) was moved from subsection B to A. Directions were revised to complete the items frequency of assistance at discharge, willing caregiver(s), and patient lives with at discharge on admission to home health as well as all acute and post-acute care settings at discharge.

Subsection B was renamed from caregiver information to residential information and instructions were provided to complete the section only if the patient was discharged to a private residence or other community-based setting. The response options were reduced and simplified for the item addressing whom the patient lives with at discharge.

Subsection C, other discharge needs, was renamed to support needs/caregiver assistance. The item addressing the patient's ability to pay for their medications post discharge was deleted. Items referring to patients' transportation to medical appointments, outpatient therapies, and treatment and management of their medication will be captured in new items in this subsection. The new items, type of assistance needed and support needs/caregiver assistance, were added to better capture the assistance needed by the patient as well as the caregiver's ability to provide that assistance. The item referencing a willing and able caregiver was revised and moved to subsection A.

In subsection D, discharge care options, directions were slightly reworded and additional response options were added. In subsection E, discharge location information, an item regarding whether the patient was being referred for additional services was added to provide the skip pattern for this section and reduce provider burden. The item addressing whether the patient or their representative requested that the CARE tool information not be provided to the next provider was moved to the end of the section.

6.1.11 Medical Coding Information (New Section)

This section was created when the decision was to delineate the completion of items relating to the patient's primary and other diagnosis, comorbidities, complications, and procedures by coding professionals and clinicians. This section relies on the ICD-9 CM codes and allows coding professionals to submit accurate codes while the clinician completing the earlier section in the Medical Information Section focuses on the diagnoses and procedures needed to communicate patient needs to the next provider for continuity of care.

6.1.12 Other Useful Information

There were no changes made to this section.

6.1.13 Feedback

There were no changes made to this section.

SECTION 7
THE CARE TOOL: POTENTIAL CHALLENGES AND FUTURE ENHANCEMENTS

The CARE instrument was developed to meet the goals of predicting post-acute care resource needs, promoting continuity of care, and predicting outcomes for Medicare beneficiaries receiving acute and post-acute care services. In selecting items that would be included on the instrument, it was necessary to balance the issues of data needed to meet the project goals and the burden of data collection. The previous sections describe the work undertaken to identify the best items to measure key concepts related to resource utilization, continuity of care, and outcomes and to minimize burden. This section addresses potential opportunities and challenges related to the CARE tool identified at the end of the period of the CARE items set development.

7.1 Challenges

The collection of systematic assessment data requires thoughtful implementation. The individuals involved in the collection and encoding of data need to be trained to collect accurate data, and be provided with resources should questions about coding occur. Within the CARE tool, some items will be easy to complete, while others will be more difficult to code. In addition, familiarity with coding items will vary by setting. For example, functional status data are collected in all post-acute care programs, but acute care nurses do not typically document patients' functional status. As appropriate, the acute care nurses will need to work with therapists to ensure data are accurate.

During the demonstration, the engagement and training of clinicians and the follow-up support for these clinicians needs to be strong. In addition, the selection of a coordinator at each site who will champion the project is critical.

The use of the Web-based tool will minimize some of these challenges. The electronic tool contains drop-down menus and automatically incorporates skip pattern logic to reduce provider burden. Supplemental items that are not relevant will not appear to the respondent. Further individual respondents can skip directly to the section of the tool they are completing by clicking on that subsection designation at the left of the screen. This new tool will provide the backbone of a standardized assessment tool across the U.S.

7.2 Future Opportunities

The development of the CARE instrument with a web-based platform also provides opportunities for future enhancements by building on the current tool. The development of the CARE tool described in this report represents the initial effort to develop a core set of items that measure the characteristics and needs of typical patients. One possible enhancement is the addition of items that further characterize a patient's medical condition in terms of severity and health care services needed. Two examples of diagnosis-specific data that are routinely collected by health care providers are provided below.

7.2.1 Patients with Stroke

The severity of post-stroke deficits vary considerably, and the addition of items specific to stroke survivors could improve prediction of resource utilization and promote improved continuity of care for these populations. Examples of two items that could be added for patients with stroke could include:

National Institutes of Health Stroke Scale (NIHSS)

The NIHSS is a systematic assessment tool that gives a quantitative measure of stroke-related neurologic deficit. The NIHSS is a 15-item neurologic examination stroke scale used to evaluate the effect of acute cerebral infarction on the levels of consciousness, language, neglect, visual-field loss, extraocular movement, motor strength, ataxia, dysarthria, and sensory loss. Ratings for each item are scored with 3 to 5 grades with 0 as normal, and there is an allowance for untestable items (Brott, Adams, Olinger, et al., 1989; Goldstein, Bertels, and David, 1989; Muir, Weir, Murray, et al., 1996).

The NIHSS has established reliability and validity for use in prospective clinical research to assess the efficacy of pharmacologic interventions in acute stroke management trials (Brott, Haley, Levy, et al., 1992; Wityk, Pessin, Kaplan, et al., 1994; Tilley, Marler, and Geller, 1996) and has recently been applied to the rehabilitation setting (Heinemann, Harvey, McGuire, et al., 1997; Roth, Heinemann, Lovell, et al., 1998; Harvey, Roth, Heinemann, et al., 1998). The NIHSS is valid for predicting lesion size and can serve as a measure of stroke severity (Brott, Adams, Olinger, et al., 1989; Saver, Johnston, Homer, et al., 1999). The NIHSS has been shown to be a predictor of both short- and long-term outcome of stroke patients. In addition, the stroke scale serves as a data collection tool for planning patient care and provides a common language for information exchanges among health care providers. The scale is designed to be a simple, valid, and reliable tool that can be administered at the bedside consistently by physicians, nurses or therapists, including hospital disposition and total length of hospitalization (Schlegel, Tanne, Demchuk, et al., 2004; Apprelos, 2007).

In addition, the NIHSS can serve as a data collection tool for planning patient care and provides a common language for information exchanges among health care providers. The scale can be administered at the bedside consistently by physicians, nurses, or therapists with excellent reliability and validity after only a few hours of training.

Even though some of the individual items of the NIHSS are covered in the CARE tool, it would be valuable to have the individual item rating, as well as the total NIHSS score. Having this information available would allow clinicians to determine if the stroke patient is receiving the appropriate level of rehabilitation and assist them to anticipate the resource needs of these patients.

Use of Anticoagulation Medications

Stroke patients commonly have one or more of the preexisting medical conditions and secondary medical complications that make the use of anticoagulants necessary. (Roth, Lovell, Harvey, et al., 2001; Roth, Lovell, Harvey, et al., 2002; Roth and Lovell, 2003; McLean, 2004; Saxena, Ng, Yong, et al., 2006). Anticoagulation medications may be given to treat preexisting medical conditions such as atrial fibrillation, myocardial infarction, and ischemic heart disease.

They also may be given to treat secondary complications of the stroke such as prevention of venous thromboembolism or prevention of a secondary stroke.

While these medications are considered to be safe and effective, the use of anticoagulation medications has been associated with an increased risk of bleeding. Bleeding that is intracranial or retroperitoneal can have a significant impact on the mortality and morbidity of stroke patients. Future versions of the tool may want to add anticoagulants as a check box for all stroke patients to avoid adverse events.

There is evidence that the risk of bleeding is associated with the dosage of anticoagulant therapy, the age of the patient, presence of uncontrolled hypertension, a history of cerebrovascular disease, and ischemic heart disease (Levine, Raskob, Beyth, et al., 2004; Hughes and Lip, 2007).

In addition, stroke patients are often on multiple medications and there may be significant drug interactions between the anticoagulants and these medications. For example, the use of certain antibiotics to treat infections may increase the effect of the anticoagulant and thereby increase the risk of bleeding.

Because of the medical complexity of many stroke patients and the potential adverse effects of anticoagulants, it is important that treating physicians be particularly aware of their use in stroke patients.

For patients with a stroke, use of anticoagulants is extremely useful for care management, but requires close monitoring in order to prevent intracranial bleeding.

Patients with a Spinal Cord Injury

A second example of possible diagnosis-specific items is targeted for persons with a spinal cord injury. The severity of deficits varies tremendously, and the collection of additional data may improve prediction of resource utilization in post-acute care and improve continuity of care. The items described below are included in the Model Spinal Cord Injury Care Systems' Dataset (as of February 2008), an effort funded and implemented by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and currently in use in 14 Model Spinal Cord Injury Systems of Care. These items are standard supplemental information for treating these populations, and range from factors specifying the extent of spinal impairment or the level of individual functional impairments associated with the injury.

Category of Neurologic Impairment

This variable documents the type and level of spinal cord injury at the time of discharge. The neurologic exam requires training using the guidelines in the International Standards for Neurological Classification of Spinal Cord Injury, published by the American Spinal Injury Association (ASIA).

CODES:

1 Paraplegia, incomplete
2 Paraplegia, complete
3 Paraplegia, minimal deficit *(see page 161)*

4 Tetraplegia, incomplete
5 Tetraplegia, complete
6 Tetraplegia, minimal deficit *(see page 161)*
7 Normal neurologic *(see page 161)*
8 Normal neurologic, minimal neurologic deficit
9 Unknown/Not Done

ASIA Impairment Scale (modified from Frankel)

This variable attempts to quantify the degree of impairment for patients with spinal cord injuries.

CODES:

A Complete Injury. No sensory or motor function is preserved in the sacral segments S4-S5.
B Incomplete. Sensory but not motor function is preserved below the neurological level and includes the sacral segments S4-S5.
C Incomplete. Motor function is preserved below the neurological level, and more than half of the key muscles below the neurological level have a muscle grade less than 3 (grades 0-2).
D Incomplete. Motor function is preserved below the neurological level, and **at least half** of key muscles below the neurological level have a muscle grade greater than or equal to 3.
E Normal. Sensory and motor function are normal. *(see page 161)*
U Unknown/Not Done
Not admitted to System inpatient Rehab *(Rehab Admit Only)*

ASIA Motor Index Score

This variable documents (1) the individual scores for each key muscle, (2) the subtotal scores for the left and right sides, and (3) the total ASIA Motor Index Scores:

1) at initial system examination *(for day-1 admissions only)*
2) within 1 week of beginning the inpatient rehabilitation stay *(for day-1 admissions only)*
3) at discharge *(for all patients)*

CODES:

Each Key Muscle 0-5 Valid range
8 Not applicable, unable to test; infants
9 Unknown, Not Done
No System rehab admission

Sensory Level

The sensory level (which may differ by side of body) is the most caudal segment of the spinal cord with normal sensory function for pinprick and light touch on both sides of the body.

CODES:

C Cervical (C1–C8)
T Thoracic (Dorsal, T1–T12)
S Sacral (S1–S5)

X00 Normal neurologic *(see page 161)*
X99 Unknown/Not Done

Motor Level

The motor level (the lowest normal motor segment, which may differ by side of body) is defined by the lowest key muscle that has a grade of at least 3, provided the key muscles represented by segments above that level are judged to be normal (5). Right and left levels are documented

CODES:

C Cervical (C1–C8)
T Thoracic (Dorsal, T1–T12)
S Sacral (S1–S5)
X00 Normal neurologic
X99 Unknown/Not Done

Method of Bladder Management

This variable defines the primary method of bladder management being used. It is much more specific than the related measures currently included in this first generation of the CARE tool, but is consistent with the national model programs for spinal cord injuries.

CODES:

00 None: The patient has a neurogenic bladder but does not follow any established program of bladder management. This includes diapers, pampers, etc.
01 Indwelling urethral catheter: Bladder is emptied by any type of catheter which is maintained through the urethra.
02 Indwelling catheter after augmentation or continent diversion: Bladder is emptied by any type of catheter which is maintained through the stoma.
Catheter Free With External Collector
The patient voids satisfactorily using any method of reflex stimulation or any form of extrinsic pressure. However, an external collector is utilized to control incontinence.
03 Catheter free with external collector, no sphincterotomy
04 Catheter free with external collector and sphincterotomy
05 Catheter free with external collector, sphincterotomy unknown
06 Catheter free without external collector: The patient voids satisfactorily using any method of reflex stimulation or any form of extrinsic pressure. An external collector is not required in that the patient has developed adequate continence.
07 Intermittent Catheterization Program **ICP only**
08 ICP with external collector
09 ICP after augmentation or continent diversion
10 ICP—external collector, augmentation or continent diversion unknown
11 Conduit: The bladder is drained by any of the surgical techniques using various portions of the intestinal tract that are not categorized as bladder augmentation.
12 Suprapubic Cystostomy: The bladder is drained by any of the surgical techniques using a catheter through a suprapubic orifice.

13 Normal Micturition (old code 4): The patient voids satisfactorily without using reflex stimulation or extrinsic bladder pressure voiding techniques. The bladder, however, may or may not have completely normal function.
14 Other: All other bladder drainage techniques such as ureterocutaneostomy (pyelostomy), electro-stimulation, electro-magnetic ball valve, detrusor stimulation, sacral implants, conus implants, vesicostomy, urethral catheterization, etc.
99 Unknown

National Spinal Cord Injury Statistical Center

National Spinal Cord Injury Statistical Center. https://www.nscisc.uab.edu/. Accessed January 5, 2008.

7.3 Summary

The development and implementation of a systematic assessment tool to predict resource use and outcomes and to promote continuity of care poses significant challenges. The engagement, training, and support of data collectors and other key facility staff will be critical to accurate data collection. The development of the first-generation CARE instrument is built to reflect a core set of data needed to understand the complexity of each Medicare beneficiary's case. This version represents a set of compromises and negotiations that build on the most current scientific research in each area (medical, functional, cognitive, and social support) but is limited to those factors predicting resource needs or outcomes. Factors specific to less common diseases and injuries are not yet included. Much work remains to be done to build a comprehensive item bank that can measure the acuity of all Medicare patients at a refined granular level.

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APPENDIX A:
COMPARISON OF LEGACY TOOL ITEMS AND THE CARE TOOL ITEMS

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Table A-1
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
I. Administrative items	—	—	—	—	—
Assessment Type	(From MDS 2.0) **A8. Reasons for assessments.** a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 10. Significant correction of prior quarterly assessment 0. None of above b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment	No equivalent item.	**M0100.** This assessment is currently being completed for the following reason: 1. Start of care – further visits planned. 3. Resumption of care (after inpatient stay) 4. Recertification (follow-up) reassessment. 5. Other follow-up 6. Transferred to an inpatient facility-patient not discharged from agency 7. Transferred to an inpatient facility-patient discharged from agency 8. Death at home 9. Discharge from agency	**C0040**. Reason for Assessment 1. Initial assessment 2. Reassessment	Proposed Item A1. Reason for Assessment: 1. Acute discharge 2. PAC admission 3. PAC discharge 4. Interim 5. Expired ——————— This item is included on the tool for tracking purposes and for identifying the time and reason for assessment.
Provider Information	(From MDS 2.0) **AA. Facility Provider Number** State Number Federal Number	**1. Facility Information** A. Facility Name B. Facility Medicare Provider Number	Unavailable.	**C0010. Site ID** **C0020. Participant ID**	Proposed Item B. Provider Information B1. Provider's Name B2 Medicare Provider's Identification Number B3. National Provider Identification Code (NPI) ——————— This item is included on the tool for tracking purposes.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Patient Information	(From MDS 2.0) **AA. Identification Information** 1. Resident Name 2. Gender 3. Birthdate 4 Race/Ethnicity 1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin 5. Social Security Number 7. Medicaid Number (From MDS 3.0) A. Select Demographic Items A2. Gender A3 Language. Does the resident need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes, specify language 9. Unable to determine A4. Ethnicity. Is the resident of Hispanic or Latino origin or descent? 0. No 1. Yes 9. 9. Unable to determine A5. Race. a. American Indian or Alaska Native b. Asian c. Black or African American d. Native Hawaiian or Other Pacific Islander e. White f. Other g. Unable to determine	2. Patient Medicare Number 3. Patient Medicaid Number 4. Patient First Name 5A. Patient Last Name 5B. Patient Identification Number 6. Birth Date 7. Social Security Number 8. Gender 9. Race/Ethnicity A. American Indian or Alaska Native B. Asian C. Black or African American D. Hispanic or Latino E. Native Hawaiian or Other Pacific Islander F. White 10. Marital Status 1. Never Married 2. Married 3. Widowed 4. Separated 5. Divorced	Unavailable.	**C0070. Gender** **C0080. Date of Birth** **C0090. Participant Social Security Number** **C0100_1. Medicare Number** **C0100_2. Medicare Entitlement** **C0110_1. Medicaid Number** **C0110_2. Medicaid Eligibility** **C0120. Ethnicity. Is the participant Hispanic or Latino (as identified by participant)** 1. No 2. Yes UK. Unknown **C0130. Race** 1. American Indian or Alaska Native 2. Asian 3. Black or African-American 4. Hispanic or Latino 5. Native Hawaiian or Other Pacific Islander 6. White 7. Other (specify) UK. Unknown **C0140. Current Marital Status** 1. Married 2. Widowed 3. Divorced 4. Separated 5. Never Married **C0150. Highest Level of Education Completed** **C0160_1. Primary Language** **C0160_2. English Fluency**	**Proposed Items** **C1. Patient's First Name** **C2. Patient's Middle Name** **C3. Patient's Last Name** **C4. Patient's Nickname (optional)** **C5. Patient's Medicare Health Insurance Number** **C6. Patient's Medicaid Number** **C7. Patient's Identification/Provider Account Number** **C8. Birth Date** **C9. Social Security Number (optional)** **C10. Gender** **C11. Race/Ethnicity** a. American Indian or Alaska Native b. Asian c. Black or African American d. Hispanic or Latino e. Native Hawaiian or Pacific Islander f. White g. Unknown **C12. Is English the patient's primary language?** 0. No 1. Yes **C12a. If not, is an interpreter available?** 0. No 1. Yes **C12b. If not, what is the patient's primary language?** _____ These items provide demographic information and are important for tracking purposes.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Advance Care Directives	(From MDS 2.0) **A10. For those items with supporting documentation in the medical record, check all that apply.** a. Living will b. Do not resuscitate c. Do not hospitalize d. Organ donation e. Autopsy request f. Feeding restrictions g. Medication restrictions h. Other treatment restrictions i. None of the above.	No equivalent item.	No equivalent item.	No equivalent item.	**Proposed Item** **C13a.** Are the patient's choices concerning future treatment documented in the medical record? 0. No 1. Yes **C13b.** Does the medical record document who has authority to make decisions if the patient is unable? 0. No 1. Yes **C13c.** Does the medical record document whether to resuscitate patient if cardiopulmonary arrest occurs? 0. No 1. Yes _____ These advanced directives items are important to communicate during transitions.
Payer Information	No equivalent item.	**20. Payment Source** A. Primary Source B. Secondary Source 01. Blue Cross 02. Medicare non-MCO 03. Medicaid non-MCO 04. Commercial insurance 05. MCO HMO 06. Workers' Compensation 07. Crippled Children's Services 08. Developmental Disabilities Services 09. State Vocational Rehabilitation 10. Private Pay 11. Employee Courtesy 12. Unreimbursed 13. CHAMPUS 14. Other 15. None 16. No Fault Auto Insurance 51 Medicare MCO 52. Medicaid MCO	No equivalent item.	No equivalent item.	**Proposed Item** **D. Payer Information: Current Payment Source(s)** D1. None (no charge for current service) 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., CHAMPUS, VA, etc) D9. Private insurance/Medigap D10. Private HMO/managed care D11. Self-pay D12 Other (specify) D13. Unknown _____ This item is important for understanding reimbursement for services.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
II. Admission information	—	—	—	—	—
Admission Date	**A1. Assessment Reference Date**	12. Admission Date	**M0090. Date Assessment Completed** **M0180. Inpatient Discharge Date**	**C0050. Date Assessment Completed**	**Proposed Item** **A1. Admission Date** _____ This item is important for tracking purposes.
Admitted From	(From MDS 2.0). **AB2. Admitted From (at entry)** 1. Private home/apt. with no home health services 2. Private home/apt with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other	**15. Admit From** 01. Home 02. Board & Care 03. Transitional Living 04. Intermediate Care 05. Skilled Nursing Facility 06. Acute Unit of Own Facility 07. Acute Unit of Another Facility 08. Chronic Hospital 09. Rehabilitation Facility 10. Other 12. Alternate Level of Care Unit 13. Subacute Setting 14. Assisted Living Residence	**M0175.** From which of the following inpatient facilities was the patient discharged during the past 14 days? 1. Hospital 2. Rehabilitation facility 3. Skilled nursing facility 4. Other nursing home 5. Other (specify) NA. Patient was not discharged from an inpatient facility.	No equivalent item.	**Proposed Item** **A2. Admitted From. Immediately preceding this admission, where was the patient?** 1. Directly from community (e.g., private home, assisted living, group home, adult foster care, long term nursing facility) 2. Skilled nursing facility (includes subacute SNF, transitional care unit) 3. Short-stay acute hospital (IPPS) 4. Long-term care hospital (LTCH) 5. Inpatient rehabilitation hospital or unit (IRF) 6. Psychiatric hospital or unit 7. Inpatient Hospice 8. Other (specify) _____ This item is included on the CARE tool for tracking purposes.
Primary Diagnosis at Previous Setting	No equivalent item.	No equivalent item.	**M0190**. Inpatient Diagnoses and ICD-9-CM code.	No equivalent item.	**Proposed Item** **A3. If admitted from a medical setting what was the primary diagnosis in the previous setting?** A3a. Last Primary Diagnosis A3b. ICD-9-CM Code _____ This item is included on the CARE tool for continuity of care purposes.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Prior Services	**O6. Physician Examinations.** Over the last 5 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident? **O7. Physician Orders.** Over the last 5 days, on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?	No equivalent item.	No equivalent item.	**C0020-C1330. Inpatient and Emergency Services Utilization.** A table that requests the following: Participant ID Participant Name Admit Type Admission Date Discharge Date Length of Stay (days) #ICU or CCU days Discharge Disposition Primary Discharge Diagnosis Secondary Discharge Diagnosis Hospital Admission Reason Nursing Home Admission Reason	**Proposed Item.** **A4**. In the last 2 months what other medical services besides those identified in A2 has the patient received? a. Skilled nursing facility (includes subacute SNF, transitional care unit) b. Short-stay acute hospital (IPPS) c. Long-term care hospital (LTCH) d. Inpatient rehabilitation hospital or unit (IRF) e. Psychiatric hospital or unit f. Home health g. Hospice h. Outpatient i. None This item is included on the tool to help understand prior resource utilization and patient severity.
Prior Residence	No equivalent item	**N16. Pre-Hospital Living Setting.** 1. Home 2. Board and Care 3. Transitional Living 4. Intermediate Care 5. Skilled Nursing Facility 6 Acute Unit of Own Facility 7. Acute Unit of Another Facility 8. Chronic Hospital 9. Rehabilitation Facility 10. Other 12. Alternate Level of Care 13. Subacute Setting 14. Assisted Living Residence	**M0300. Current residence:** 1. Patient's owned or rented residence (house, apartment or mobile home owned or rented by patient/couple/significant other) 2. Family member's residence 3. Boarding home or rented room 4. Board and care or assisted living facility 5. Other (specify).	**C0580: Current residence:** 1. Patient's owned or rented residence (house, apartment or mobile home owned or rented by patient/couple/ significant other) 2. Family member's residence 3. Boarding home or rented room (not PACE housing) 4. Assisted living or board and care facility (may provide congregate meals but no personal care or supervision; not PACE housing) 5. Assisted living or board and care facility WITH personal care or supervision; not PACE housing 6. PACE program-related housing 7. Group home except foster care (provides around-the-clock personal care and supervision) 8. Foster care in a group home 9. Nursing home (temporary) 10.Nursing home (permanent) 11. Other (specify)_____	**Proposed Item:** A1. Prior Residence. Prior to this recent illness, where did the patient live? 1. Private residence 2. Community based residential facility (e.g., assisted living residence, group home, adult foster care) 3. Permanently in a long term care facility (e.g., nursing home, chronic care hospital) 4. Other (shelter, jail, no known address, etc.) 9. Unknown • This item is highly predictive of PAC setting. For example, if a patient is in a nursing home prior to hospital admission, it is likely that the patient will return to this setting. This is likely also true about assisted living. (1994 data, research by Chris Murtaugh). It is not useful for setting payments. • Change in residence prior to and post care is an important outcome measure. • This item only needs to be measured once.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Prior Residence (continued)	No equivalent item	—	—	—	**Comments (continued):** • When adapting this item from the legacy instruments, the group considered that there have been too many response categories with unclear distinctions in other instruments. To reduce burden and make the item more user friendly, the group limited the number of response categories and tried to ensure that there are clear distinctions between each one. • This item may also be associated with pre-admission functional status. • It may also be informative to capture whether a patient still owns a home.
Prior Lives With	**(MDS 2.0)** **3.** Live Alone (prior to entry) 0. No 1. Yes 2. In other facility	**N17**. Pre-Hospital Living With. 1. Alone 2. Family/Relatives 3. Friends 4. Attendant 5. Other	**M0340.** Patient lives with: 1. Lives alone 2. With spouse or significant other 3. With other family member 4. With a friend 5. With paid help (other than home care agency staff) 6. With other than above	**C0590.** Participant Lives With: (mark all that apply): 1. Lives alone 2. With spouse or significant other 3. With other family member 4. With a friend 5. With paid family caregiver 6. With paid help other than PACE staff or family caregiver (includes foster care) 7. With other than above (specify):	**Proposed Item:** Prior Patient Lives With. Prior to the episode of care, who did the patient live with? Check all that apply. 1. Lives alone 2. Spouse or Significant Other 3. Adult Child (≥ 18 years) 4. Other unpaid family member or friend 5. Paid help living in the home (other than home care) ——————————— • This item is important for understanding placement particularly if the patient does not have someone to live with and needs assistance. Note that having a spouse does not predict settings. • The item captures the availability of 24 hour care from informal caregivers in the home. • Only needs to be completed if patient lived in a private residence prior to episode of care. It only needs to be completed once. • This item is more specific than prior residence and gets to who is actually going to be providing care or support. • This item is highly predictive for where the patient will end up after acute care discharge. • The item can be difficult to capture and is not very clearly associated with outcomes. • Compared to legacy instrument items, the CARE tool recommendation is to limit the number of response categories and to capture more distinct and meaningful categories.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Zip Code	(From MDS 2.0) **AA4. Zip Code of Prior Primary Residence**	**11. Zip code of Patient's Pre-Hospital Residence.**	No equivalent item.	No equivalent item.	**Proposed Item** **B2.** If the patient lived in the community prior to this illness, please provide the patient's zip code (if patient's residence was in the U.S.). _____ This item is useful for patient tracking purposes.
Structural Barriers	No equivalent item	No equivalent item	**M0310.** Structural barriers in the patient's environment limiting mobility: 1. None 2. Stairs inside home which must be used by the patient (e.g., to get to toileting, sleeping, eating areas) 3. Stairs inside the home which are used optionally (e.g., to get to laundry facilities) 4. Stairs leading from inside to outside of house; 5. Narrow or obstructed doorways _____ M0320. Safety hazards found in the patient's current place of residence: 1. None 2. Inadequate floor, roof or windows 3. Inadequate lighting 4. Unsafe gas/electrical appliance 5. Inadequate heating; 6. Inadequate cooling 7. Lack of fire safety devices; 8. Unsafe floor coverings 9. Inadequate stair railings 10. Improperly stored hazardous materials; lead-based paint 11. Other (specify).	C1010. Structural Barriers: indicate any structural barriers present in the participant's home environment that limit independent mobility 1. None 2. Stairs inside home which must be used by the patient (e.g., to get to toileting, sleeping, eating areas) 3. Stairs inside the home which are used optionally (e.g., to get to laundry facilities) 4. Stairs leading from inside to outside of house; 5. Narrow or obstructed doorways	**Proposed Item:** **Structural Barriers.** Are there any structural barriers that will interfere with patient care in the setting targeted for the patient's discharge? (Check all that apply) 1. Structural barriers are not an issue 2. Stairs inside the living setting that must be used by patient (e.g., to get to toileting, sleeping, eating areas) 3. Stairs leading from inside to outside of living setting 4. Narrow or obstructed doorways for patients using wheelchairs or walkers 5. Insufficient space to accommodate extra equipment (e.g., hospital bed vent equipment) _____ • This item is not important for setting payments or measuring outcomes, however, it does provide some information for predicting settings. Major obstacles in the home may prevent discharge to this setting. • This item is a crude measures of living setting access issues • Stairs/other structural barriers inside the home are of particular interest because these could limit the ability of an individual to function individually in the home. • Narrow or obstructed doorways may be an issue for patients in a wheelchair • The group thought it would be important to capture the need for extra space to accommodate medically necessary equipment (e.g., vent) • The group considered social barriers such as telephone access, transportation access, electricity access etc. Are this equally important to be captured?

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Structural Barriers (continued)	No equivalent item	No equivalent item	**M0330.** Sanitation hazards found in patient's current place of residence: 1. None 2. No running water 3. Contaminated water 4. No toileting facilities 5. Outdoor toileting facilities only 6. Inadequate sewage disposal 7. Inadequate/improper food storage 8. No food refrigeration 9. No cooking facilities 10. Insects/rodents present 11. No scheduled trash pick up 12. Cluttered/soiled living area 13. Other (specify)	—	The living situation items relating to safety and sanitation may lead to some privacy issues and are not applicable for a wide range of patient populations. Therefore, the group does not recommend including these items in the CARE tool. These items have also raised some questions on the OASIS.
Prior Functioning	**G2. Mobility Prior to Admission.** Complete only on admission assessment. a. Did resident have a hip fracture, hip replacement, or knee replacement in the 20 days prior to this admission? 0. No 1. Yes 9. Unable to determine b. If yes, check all that apply for tasks in which the resident was independent prior to fracture/replacement. 1. Transfer 2. Walk across room 3. Walk 1 block on a level surface 4. Resident was not independent in any of these activities 9. Unable to determine	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **B5. Prior Functioning.** Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation or injury. B5a. Self Care: Did the patient need help bathing, dressing or eating? B5b. Mobility (Ambulation): Did the patient need assistance with walking from room to room (with or without devices such as cane, crutch, or walker)? B5c. Stairs (Ambulation): Did the patient need assistance with stairs (with or without devices such as a cane crutch or walker)? B5d. Mobility (Wheelchair): Did the patient need assistance with moving from room to room using a wheelchair, scooter, or other wheeled mobility device? B5e. Functional Cognition. Did the patient need help planning regular tasks, such as shopping or remembering to take medication? **Rating Scale:** 3. Independent—Patient completed the activities by him/herself, with or without an assistive device with no assistance from a helper. 2. Needed some help—Patient needed some help from another person to complete activities. 1. Dependent—A helper completed the activity for the patient. 9. Unknown.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Mobility Devices and Aids	**G5. Gait and Locomotion**. Check all that were normally used in the past 5 days. a. Crane/crutch b. Walker c. Wheelchair (manual or electric) d. Limb prosthesis e. None of the above were used.	No equivalent item.	No equivalent item.	No equivalent item.	**Proposed Item** **B6.** Mobility devices and aids used prior to current illness, exacerbation, or injury. a. Crane/crutch b. Walker c. Wheelchair/scooter full time d. Wheelchair/scooter part time e. Mechanical lift required f. Other (specify) _____ This item is useful for understanding patient severity and potential resource needs. It would be important to communicate this type of information during transitions of care.
Fall History	**J16. Fall History (Admission)** a. Did the resident fall one or more times in the 30 days (i.e., month) before admission? 0. No 1. Yes 9. Unable to determine b. Did the resident fall one or more times in the 31-180 days (i.e., 1-6 months) before admission? 0. No 1. Yes 9. Unable to determine c. Did the resident have any fracture related to fall in the 6 months prior to admission? 0. No 1. Yes 9. Unable to determine d. Has the resident fallen since admission to the nursing home? 0. No 1. Yes	No equivalent item.	No equivalent item	No equivalent item.	**Proposed Item** **B7. History of Falls.** Does the patient have a history of falls? 0. No 1. Yes 9. Unknown _____ History of fall is a predictor of future resource utilization and resource needs. Recurrent falls are fairly common among elderly populations.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Prior Mental Status	**C13. Acute Onset Mental Status Change** Is there any evidence of an acute change in mental status from the resident's baseline in the last 5 days? 1. Yes 0. No	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **B8. Prior Mental Status**. Is there any evidence of an acute change in mental status from the patient's status prior to this current illness, exacerbation or injury? 0. No 1. Yes 9. Unknown _____ This item captures mental status at admission and allows for proper resource planning and understanding of patient outcomes.
III. Current medical items	—	—	—	—	—
A. Primary Diagnosis (Acute care and then post acute care if appropriate)	**Section I. Active diseases in the last 30 days.** **Cancer** 1. Cancer (with or without metastases) **Heart/Circulation** 2. Anemia (includes aplastic, iron deficiency, pernicious and sickle cell) 3. Atrial Fibrillation and Other Dysrhythmias (includes bradycardias, tachycardias) 4. Coronary Artery Disease (includes angina, myocardial infarction) 5. Deep Venous Thrombosis/ Pulmonary Embolus 6. Heart Failure (includes pulmonary edema) 7. Hypertension 8. Peripheral Vascular Disease/Peripheral Arterial Disease 9. Other Heart/ Circulation: enter diagnosis and ICD9:_____	**21. Impairment Group** Admission _____ Discharge _____ Condition requiring admission to rehabilitation; code according to Appendix A, attached. _____ **22. Etiologic Diagnosis** Use an ICD-9-CM code to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation. _____ **23. Date of Onset of Impairment**	**M0190. Inpatient Diagnoses** and ICD-9-CM code categories (three digits required; five digits optional) <u>for only those conditions treated during an inpatient facility stay within the last 14 days</u> (no surgical or V-codes). _____	**C0240. Diagnoses and Severity Index.** List each of the participant's current medical diagnoses and the associated ICD-9-CM code at the level of highest specificity (no surgical codes). E-codes or V-codes may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnosis. Rate each diagnosis using the severity rating described below. (Choose one value that represents the most severe rating appropriate for each diagnosis). Also indicate for each diagnosis whether it is acute or a chronic condition. _____ **Severity Rating** Choose a value that represents most severe rating for each diagnosis.	**Proposed Item:** **Primary Diagnosis.** Indicate the primary diagnosis at discharge and associated ICD-9 code. If a V-code is used, also indicate the medical diagnosis. Be as specific as possible. _____ • Previous research has indicated that the accuracy of ICD-9 coding is poor, especially in post acute care. For post acute care, the group offers, as an alternative, a list of diagnoses that includes both common and under-reported diagnoses (Appendix A). To generate this list of diagnoses the group reviewed diagnoses and diagnostic categories in the legacy instruments, the MDC and the RIC. The same diagnostic list could be applied to other diagnosis questions such as the comorbidities/complications and medical history questions.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
A. Primary Diagnosis (continued)	**Gastrointestinal** 10. Cirrhosis 11. GERD/Ulcer (includes esophageal, gastric, and peptic ulcers) 12. Ulcerative Colitis/ Chrohn's Disease/Inflammatory Bowel Disease 13. Other Gastrointestinal: enter diagnosis and ICD-9:_____ **Genitourinary** 14. Benign Prostatic Hyperplasia 15. Renal Insufficiency 16. Other Genitourinary: enter diagnosis and ICD-9:_____ **Infections** 17. Human Immunodeficiency Virus (HIV) Infection (includes AIDS) 18. MRSA, VRE, Clostridium diff. Infection / Colonization 19. Pneumonia 20. Tuberculosis 21. Urinary Tract Infection 22. Viral Hepatitis (includes Hepatitis A, B, C, D, and E) 23. Wound Infection 24. Other Infections: enter diagnosis and ICD-9_____ **Metabolic** 25. Diabetes Mellitus (includes diabetic retinopathy, nephropathy, and neuropathy) 26. Hyponatremia 27. Hyperkalemia 28. Hyerlipidemia 29. Thyroid Disorder (Includes hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis) 30. Other Metabolic: enter diagnosis and ICD-9:_____	—	**M0245. Payment Diagnosis (optional):** If a V-code was reported in M0230 in place of a case mix diagnosis, list the primary diagnosis and ICD-9-CM code, determined in accordance with OASIS requirements in effect before October 1, 2003--no V-codes, E-codes, or surgical codes allowed. ICD-9-CM sequencing requirements must be followed. Complete both lines (a) and (b) if the case mix diagnosis is a manifestation code or in other situations where multiple coding is indicated for the primary diagnosis; otherwise, complete line (a) only a. (M0245) Primary Diagnosis ICD-9-CM b. (M0245) First Secondary Diagnosis ICD-9-CM _____ **M0230/M0240. Diagnoses and Severity Index:** List each medical diagnosis or problem for which the patient is receiving home care and ICD-9 code category (three digits required; five digits optional – no surgical or v-codes) and rate them using the following severity index. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnosis.	0. Asymptomatic, no treatment needed at this time 1. Symptoms well controlled with current therapy 2. Symptoms, controlled with difficulty, affecting daily functioning; participant needs ongoing monitoring 3. Symptoms, poorly controlled, participant needs frequent adjustments in treatment and dose monitoring. 4. Symptoms poorly controlled, history of rehospitalizations **Acute or Chronic Condition** For each medical diagnosis listed, indicate if the condition is acute or chronic. 0. Acute 1. Chronic	• This item helps set payments and measure outcomes but does not necessarily predict settings. • The item's main strength is that it collects ICD-9 codes which are an important indicator of patient severity. • Poor coding practices may affect the reporting of this item. There is also some potential for gaming the system.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
A. Primary Diagnosis (continued)	**Musculoskeletal** 31. Arthritis (Degenerative Joint Disease, Osteoarthritis, and Rheumatoid Arthritis) 32. Osteoporosis 33. Hip Fracture (includes any hip fracture that continues to have a relationship to current status, treatments, monitoring. Includes sub-capital fractures, fractures of the trochanter and femoral neck) (last 90 days) 34. Other Fracture 35. Other Musculoskeletal: enter diagnosis and ICD-9:_____ **Neurological** 36. Alzheimer's Disease 37. Aphasia 38. Cerebral Palsy 39. CVA/ TIA/ Stroke 40. Dementia (Non-Alzheimer's dementia, including vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia (e.g., Pick's disease), and dementia related to stroke, Parkinson's, Huntington's, Pick's, or Creutzfeldt-Jakob diseases) 41. Hemiplegia/Hemiparesis/ Paraplegia/Quadriplegia 42. Multiple Sclerosis 43. Parkinson's Disease 44. Seizure Disorder 45. Traumatic Brain Injury 46. Other Neurological: enter diagnosis and ICD-9_____ **Nutritional** 47. Protein Calorie Malnutrition or at risk for malnutrition 48. Other Nutritional: enter diagnosis and ICD-9_____	—	**Severity Rating**. Choose one value that represents the most severe rating appropriate for each diagnosis. 0. Asymptomatic, no treatment needed at this time 1. Symptoms well controlled with current therapy 2. Symptoms, controlled with difficulty, affecting daily functioning; participant needs ongoing monitoring 3. Symptoms, poorly controlled, participant needs frequent adjustments in treatment and dose monitoring. 4. Symptoms poorly controlled, history of rehospitalizations	—	—

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
A. Primary Diagnosis (continued)	**Psychiatric/Mood Disorder** 49 Anxiety Disorder 50. Depression (other than Bipolar) 51. Manic Depression (Bipolar Disease) 52. Schizophrenia 53. Other Psychiatric/Mood Disorder: enter diagnosis and ICD-9_____ Pulmonary 54. Asthma/ COPD Chronic Lung Disease (includes restrictive lung diseases such as asbestosis and chronic bronchitis) 55. Other Pulmonary: enter diagnosis and ICD-9:_____ Other 56. Note Additional Diagnoses (up to 5): enter diagnosis and ICD-9:_____	—	—	—	—

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Other Diagnoses, Comorbidities and Complications	No equivalent item.	**24. Comorbid Conditions**. Use ICD-9 codes to enter up to ten medical conditions. _____ **47. Complications during rehabilitation stay.** (Use ICD-9-CM codes to specify up to six conditions that began with this rehabilitation stay.)	**M0220. Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay within past 14 Days**: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply). 1. Urinary incontinence 2. Indwelling/suprapubic catheter 3. Intractable pain 4. Impaired decision-making 5. Disruptive or socially inappropriate behavior 6. Memory loss to the extent that supervision required 7. None of the above NA. No inpatient facility discharge and no change in medical or treatment regimen in past 14 days UK. Unknown	**C1310 Primary/Secondary Discharge Diagnosis**. Record ICD-9-CM codes for primary and secondary discharge diagnoses. These are usually available from the hospital discharge summary, hospital medical records department or physician.	**Proposed Item:** **Comorbidities and Complications.** List up to 15 diagnoses and associated ICD-9-CM. Include under-reported diagnoses (e.g., depression, schizophrenia, dementia, protein calorie malnutrition). If a V-code is listed, also list the medical diagnosis and the ICD-9-CM code for the medical diagnosis. _____ • See A. Primary Diagnosis comments. • The group recommends capturing active diagnoses, defined as diagnoses that are being actively treated, managed or monitored. • The group considered the use of the Elixhauser index to capture comorbidity. It was concluded that using the index would be overly burdensome for sites. The group used the Elixhausrer list of comorbidities as a reference when developing the list of post acute care diagnoses. • This item does not set payments but it does measure patient severity and contribute to the understanding of outcomes and resource utilization. • Poor coding practices may affect the reporting of this item. There is also some potential for gaming the system.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Procedures	No equivalent item	No equivalent item	No equivalent item	No equivalent item	**Proposed Item:** C Did the patient have one or more therapeutic or major procedure(s) during this admission? (Y/N) List up to 15 procedures (diagnostic and therapeutic interventions) performed during this admission and report the appropriate procedure code. Indicate if an orthopedic procedure was bilateral (e.g., bilateral knee replacement, bilateral hip replacement). _____ • Post-operative care is common in PAC settings as well as acute and therefore it is useful to capture major procedures provided in acute care. • There is no need to be concerned with under-reporting for some procedures, therefore the group does not recommend a check-off list for major procedures.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Treatments	**O1. Special Treatments and Programs** Complete for all assessments I. Past 5 days, or since admission if less than 5 days II. In 5 days prior to admission **Cancer Treatment** a. Chemotherapy b. Radiation Respiratory Treatments c. Oxygen therapy d. Suctioning e. Tracheostomy care f. Ventilator or respirator **Other** g. IV medications h. Transfusions i. Dialysis j. Hospice care k. Respite care l. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) m. None of the above _____ **M13. Skin Treatments** Check all that apply in the past 5 days: a. Pressure reducing device for chair b. Pressure reducing device for bed c. Turning/repositioning program d. Nutrition or hydration intervention to manage skin problems e. Ulcer care f. Surgical wound care g. Application of dressings (with or without topical medications) other than to feet h. Applications of ointments/medications other than to feet i. None of the above were provided	No equivalent item	**M0250. Therapies the patient receives at home. Mark all that apply.** 1. Intravenous or infusion therapy (excludes TPN) 2. Parenteral nutrition (TPN or lipids) 3. Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal) 4. None of the above _____ **M0500. Respiratory Treatment Respiratory treatment utilized at home. Mark all that apply.** 1. Oxygen (intermittent or continuous) 2. Ventilator (continually or at night) 3. Continuous positive airway pressure; none of the above	No equivalent item	**Proposed Item:** **D. Treatments.** Which of the following treatments are required? (Please note: "used at any time during stay" is only necessary at discharge). D1. None D2. Insulin Drip D3. Total Parenteral Nutrition D4. Central Line Management D5. Blood Transfusions D6. Controlled Parenteral Analgesia—Peripheral D7. Controlled Parenteral Analgesia—Epidural D8. Left Ventricular Assistive Device D9. Continuous Cardiac Monitoring (specify reason) D10. Chest Tube(s) D11. ET Tube Care and Management D12. Trach Tube with Suctioning (specify suctioning frequency) D13. High O2 Concentration Delivery System D14. Ventilator—Weaning D15. Ventilator—Non-weaning D16. Hemodialysis D17. Peritoneal Dialysis D18. Fistula or Other Drain Management D19. Negative Pressure Wound Therapy D20. Complex Dressing Changes D21 Halo D22 Complex External Fixators D23. One-on-One 24 Hour Supervision D24. Specialty Bed D25 Multiple IV Antibiotic Administration D26. IV Vaso-actors D27. IV Anti-coagulants D28 IV Chemotherapy D29. Indwelling Urinary Catheter D30. Intermittent Urinary Catheterization D31. Ostomy D32. External Fecal Management System _____ • The group recommends having one treatment section to capture need for non-discretionary treatments that may prevent transfer to certain settings.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Treatments (continued)	**K4. Nutritional Approaches.** Check all that applied in last 5 days: a. Parenteral/IV feeding b. Feeding-tube- nasogastric or abdominal (PEG) c. Mechanically altered diet (require change in texture of food or liquids e.g., pureed food, thickened liquids) d. Therapeutic diet (low salt, diabetic, low cholesterol) e. None of the above	No equivalent item	—	No equivalent item	—
Medications	**N1. Injections**. Record the number of days that injectable medications were received during the last 5 days or since admission if less than 5 days. **N2. Medications Received** Check all medications the resident received at any time during the last 5 days or since admission if less than 5 days: a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Anticoagulant (warfarin, heparin, or low-molecular weight heparin) f. None of the above	No equivalent item	No equivalent item	No equivalent item	**Proposed Item:** **E. Medications**. List all current medications for the patient at the 2-day assessment period. These can be exported to an electronic file for merging with the assessment data. Include Medication Name, Dose, Route, Frequency and Start and Stop Dates. ——— • The type and number of medications are useful for understanding patient severity. • Capturing a list of medications is also important for transfer. Medication reconciliation could substantially improve quality of care. • In addition to capturing the type of medication, the group believes it would be important to capture dose, route, frequency and stop dates for transfer purposes. • Most facilities keep electronic medication records that could be printed to accompany the form. The group decided that asking only for a list on the form itself could increase the likelihood of errors. It is important to note that the printout would only capture the medications that the patient receives at discharge. Any intermittent medications (e.g., chemotherapy schedule) may not be captured.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Allergies & Adverse Drug Reactions	No equivalent item	No equivalent item	No equivalent item	No equivalent item	**Proposed Item:** **F. Allergies and Adverse Drug Reactions**. Does the patient have allergies or any known adverse drug reactions? 0. None known 1. Yes If yes, list all allergies and describe adverse drug reactions. _____ • Knowing patient allergies is important for avoiding any adverse reactions. Any information gathered about allergies in one setting should be transferred to the next setting.
Pressure Ulcers	**M1. Pressure Ulcer**. Did the resident have a pressure ulcer in the last 5 days? 0. No 1. Yes **M2. Number of Pressure Ulcers**. Number of existing pressure ulcers at stage 1? **M3**. Stage 2 ulcers: **M3a.** Number of existing pressure ulcers at stage 2 (enter number) **M3b.** Number of these stage 2 pressure ulcers that were present on admission (enter number) **M3c**. Current dimensions of largest stage 2 pressure ulcer (enter length and width, both in cm)	**52A. Pressure Ulcer Stage**. Highest current pressure ulcer stage 0. No pressure ulcer 1. Any area of persistent skin redness 2. Partial loss of skin layers 3. Deep craters in the skin 4. Breaks in skin exposing muscle or bone 5. Not stageable _____ **52B.** Number of Pressure Ulcers. Number of current pressure ulcers Admission _____ Discharge _____ SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING. Calculate three components (C through E) and code total score in F.	**M0445. Pressure Ulcer**. Does this patient have a pressure ulcer? 0. No 1. Yes **M0460**. Pressure Ulcer Stage. Stage of most problematic (observable) pressure ulcer. 1. Stage 1 2. Stage 2 3. Stage 3 4. Stage 4 NA. No observable pressure ulcer	**C0290_1. Pressure Ulcer.** Does the participant have a Pressure Ulcer? 0. No 1. Yes **C0290_3. Stage of Most Problematic (observable) Pressure Ulcer** 1. Stage 1 2. Stage 2 3. Stage 3 4. Stage 4 NA. No observable pressure ulcer	**Proposed Item:** **G1.** Has this patient had a formal evaluation for risk of developing pressure ulcers? 1. Yes, and it indicated high risk (e.g., a Braden score <12 or healed scars or active pressure ulcers)? 2. Yes, and it indicated no particularly high risk. 3. No **G2.** Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher? (Y/N) If the patient has one or more stage 2-4 pressure ulcers, indicate the number of unhealed pressure ulcers at each stage. Stage descriptions – 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.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Pressure Ulcers (continued)	**M4. Stage 3 ulcers:** **M4a**. Number of existing pressure ulcers at stage 3 (enter number) **M4b.** Number of these stage 3 pressure ulcers that were present on admission (enter number) **M4c:** Current dimensions of largest stage 3 pressure ulcer (length, width, and depth all in cm) **M5. Stage 4 ulcers:** **M5a**. Number of existing pressure ulcers at stage 4 (enter number) **M5b**. Number of these stage 4 pressure ulcers that were present on admission (enter number) M5c: Current dimensions of largest stage 4 pressure ulcer (length, width, and depth all in cm) **M6.Nonstageable ulcers** **M6a**. Not stageable (enter number) **M6b**. Number of these nonstageable pressure ulcers that were present on admission (enter number) **M7. Exudate** Amount for most advanced stage. 0. None 1. Light 2. Moderate 3. Heavy 4. Not observable/not documented **M8. Tissue type for most advanced stage.** 1. Closed/resurfaced 2. Epithelial tissue 3. Granulation tissue 4. Slough 5. Necrotic tissue 6. Not observable/not documented	**52C.** Length multiplied by width (open wound surface area) 0. 0 cm2; 1. <0.3 cm2; 2. 0.3 to 0.6 cm2; 3. 0.7 to 1.0 cm2; 4. 1.1 to 2.0 cm2; 5. 2.1 to 3.0 cm2; 6. 3.1 to 4.0 cm2; 7. 4.1 to 8.0 cm2; 8. 8.1 to 12.0 cm2; 9. 12.1 to 24.0 cm2; 10. > 24 cm2 **52D. Exudate Amount** Admission____ Discharge _____ 0. None; 1. Light; 2. Moderate; 3. Heavy **52E. Tissue type** Admission_____ Discharge _____ 0. Closed/resurfaced: the wound is completely covered with epithelium (new skin) 1. Epithelial tissue: for superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface 2. Granulation tissue: pink or beefy red tissue with a shiny, moist, granular appearance 3. Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous 4. Necrotic tissue (eschar): black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges.	**M0450. Current Number of Pressure Ulcers at Each Stage.** Circle one response for each stage Number of pressure ulcers: Stage 1: 0, 1, 2, 3, 4 or more Stage 2: 0, 1, 2, 3, 4 or more Stage 3: 0, 1, 2, 3, 4 or more Stage 4: 0, 1, 2, 3, 4 or more a. Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators. b. Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. c. Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. d. Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	**C0290_2. Current Number of Pressure Ulcers at Each Stage.** Circle one response for each stage Number of pressure ulcers: Stage 1: 0, 1, 2, 3, 4 or more Stage 2: 0, 1, 2, 3, 4 or more Stage 3: 0, 1, 2, 3, 4 or more Stage 4: 0, 1, 2, 3, 4 or more a. Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators. b. Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. c. Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. d. Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	Stage 3—Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. 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 include undermining and tunneling. 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 or cast or possible deep tissue injury in evolution. **G2 (continued).** Number of unhealed stage 2 ulcers known to be present for more than 1 month. If the patient has one or more Stage 2 pressure ulcers, record the number present today that were first observed more than one 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) during the 2 day assessment period, please record the most recent measurements for the largest ulcer or eschar. **G4.** Indicate if any unhealed stage 3 or stage 4 pressure ulcer(s) has tunneling (sinus tract) present. _____ The series of pressure ulcer items was developed by a CMS workgroup including representatives from WOCN and NPUAP.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Pressure Ulcers (continued)	**M9. Data source for current pressure ulcer items (M2-M8)** 1. Research nurse direct observation with facility nurse 2. Facility nurse completing MDS 3.0 assessment 3. Chart review _____ **M10.** Worsening in pressure ulcer status since last assessment. Indicate the number of current pressure ulcers that were not present or were at a lesser stage on last MDS (if no current pressure ulcer at a given stage, enter 0) **M10a.** Check here if N/A, no prior assessment M10b. Stage 2 M10c. Stage 3 M10d. Stage 4 **M11**. **Healed Pressure Ulcers**. Indicate the number of pressure ulcers that were noted on last MDS that have completely healed. (If no current pressure ulcer at a given stage, enter 0). **M11a.** Check if N/A. (no prior assessment or no pressure ulcers on prior assessment) M11b. Number of healed stage 2 ulcers M11c. Number of healed stage 3 ulcers M11d. Number of healed stage 4 ulcers	**52F. TOTAL PUSH SCORE** sum of above three items - C, D and E) Admission_____ Discharge_____	e. In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? 0. No 1. Yes _____ **M0464. Status of most problematic (observable) pressure ulcer.** 1. Re-epithelialized 2. Fully granulating 3. Early/partial granulation 4. Not healing NA. No observable pressure ulcer	e. In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? 0. No 1. Yes _____ **C0290_4. Status of most problematic (observable) pressure ulcer** 1. Re-epithelialized 2. Fully granulating 3. Early/partial granulation 4. Not healing NA. No observable pressure ulcer	—

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Major Wound (excluding Pressure Ulcers)	**M12. Other Ulcers, Wounds, and Skin Problems**. Check all that apply in the past 5 days. a. Venous or arterial ulcer(s) b. Diabetic foot ulcer(s) c. Other foot or lower extremity infection (cellulitis) d. Surgical wound(s) e. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) f. Burn(s) g. None of the above were present	No equivalent item	**M0468. Stasis Ulcer**. Does this patient have a stasis ulcer? 0. No 1. Yes **M0470.** Current number of observable stasis ulcer(s). 1, 2, 3, 4 or more **M0474**. Does this patient have at least one stasis ulcer that cannot be observed due to the presence of a nonremovable dressing? 0. No 1. Yes **M0476.** Status of most problematic (observable) stasis ulcer. 1. Fully granulating 2. Early/partial granulation 3. Not healing 4. No observable stasis ulcer **M0482**. Does this patient have a surgical wound? 0. No 1. Yes **M0484.** Current number of (observable) surgical wounds (if a wound is partially closed but has more than one opening, consider each opening as a separate wound). 0, 1, 2, 3, 4 or more	No equivalent item	**Proposed Item:** **G5**. Does the patient have one or more major wound(s) that require ongoing care because of draining, infection, or other complications? (Y/N). **G5a-e**. Indicate the number of wounds by type. Enter "0" if there are no wounds of that type and classification. The classification definitions are: Types of Wounds: 1. Non-healing surgical wound 2. Trauma-related wound 3. Diabetic foot ulcer(s) 4. Vascular ulcer (arterial or venous including diabetic ulcers not located on the foot) 5. Other (specify) _____ • This item is adapted from standard practices at RML Specialty Hospital. • Any breaks in the skin's surface will affect resource utilization, possibly setting and helps define patient severity.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Major Wound (continued)	—	No equivalent item	**M0486. Does this patient have at least one surgical wound that cannot be observed due to the presence of a nonremovable dressing?** 0. No 1. Yes **M0488. Status of most problematic (observable) surgical wound.** 1. Fully granulating 2. Early/partial granulation 3. Not healing 4. No observable surgical wound _____ **M0440. Does this patient have a skin lesion or an open wound?** This excludes ostomies. 0. No 1. Yes	No equivalent item	—
Turning Surfaces	No equivalent item.	No equivalent item.	No equivalent item.	No equivalent item.	**Proposed Item** **G6. Turning surfaces not intact**. 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. None of the above apply _____ This item was included on the tool because it is predictive of resource utilization and contributes to the understanding of patient severity and health outcomes.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Physiologic Factors	**K2. Height** (in inches) most recent height measure since admission. (If height includes a fraction, round up to nearest inch). **K2. Weight** (in pounds) base weight on most recent measure in last 30 days; measure weight consistently according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.). (If weight includes a fraction, round up to nearest pound.)	No equivalent item.	No equivalent item	No equivalent item	**Proposed Item:** **Physiologic Factors**. Record the most recent value for each of the following physiologic factors and indicate the date (MM/DD/YYYY) that the value was collected. If the test was not provided during this admission, write NT for "not tested" under value. If it is not possible to measure height and weight, check box if value is estimated (actual measurement is preferred. H1/H2. Height (inches/cm) H3/H4. Weight (pounds/Kg) H5/H6. Temperature (Fahrenheit/Celsius) H7. Heart Rate (beats/min) H8. Respiratory Rate (breaths/min) H9. Blood Pressure (mmg/Hg) H10. O2 saturation (Pulse oximetry %) H11. Hemoglobin (gm/dL) H12. Hematocrit (%) H13. WBC (K/mm^3) H14. HbA1c (%) H15. Sodium (mEq/L) H16. Potassium (mEq/L) H17. BUN (mg/dL) H18. Creatinine (mg/dL) H19. Albumin (gm/dL) H20. Prealbumin (mg/dL) H21. INR H22. pH H23. PACO2 (mm/Hg) H24. HCO3 (mEq/L) H25. PaO2 (mm/Hg) H26. SaO2 (%) H27. BE (base excess) (mEq/L) H28. Left Ventricular Ejection Fraction (%) • Physiologic factors are important for predicting settings and measuring outcomes but are not related to payment. This item is globally predictive. • Physiologic factors are important for capturing patient severity.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Physiologic Factors (continued)	—	No equivalent item	No equivalent item	No equivalent item	• The group recognized the concern of collecting some of these lab values in home care and SNFs. This was addressed by requesting the most recent lab value and date of the lab value. Respondents are also permitted to indicate "never tested" if this is accurate. • Height and weight are important to capture as they characterize obesity. Resource utilization for the obese is much higher than the non-obese population. Also, height and weight are important for transfer. Particularly since some facilities are not equipped to accommodate the morbidly obese. • Temperature, respiratory rate, blood pressure, heart rate and oxygen saturation are all important vital signs that characterize patient severity. The set of vital signs is a standard set used in clinical settings. • Hematocrit and Hemoglobin are useful for identifying any abnormal bleeding issues, particularly after surgery. They are a good measure of patient severity. • BUN and Creatinine are useful for measuring renal function. The BUN/Creatinine ratio measures also indicate if dehydration is an issue. These labs indicate the severity of renal issues. • Albumin level is an important measure of liver function. It may also be used to determine a patient's nutritional status after significant weight loss. Abnormal albumin levels can indicate inflammation, shock, malnutrition or dehydration. • WBC may indicate infection and the need for ongoing treatment. This test is also used to monitor treatment. It is indicative of severity of infection. • Arterial blood gases (ABGs) are only completed when there is extreme respiratory compromise. The fact that ABGs were completed is an indication of patient severity. ABGs will identify the medically and surgically complex patients.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
IV. Cognitive status	—	—	—	—	—
Comatose	**B1. Comatose.** Persistent vegetative state/no discernible consciousness last 5 days. 0. No 1. Yes.	**25.** Is the patient comatose at admission? 0. No 1. Yes	No equivalent item.	No equivalent item.	**Proposed Item** **A. Comatose**. Persistent vegetative state/no discernible consciousness at time of admission (discharge). 0. No 1. Yes
Brief Interview for Mental Status	**Section C,** Questions C1-C5: Cognitive Patterns: Brief Interview for Mental Status **C1.** Interview Attempted: 0. No (resident is rarely/never understood or needed interpreter not present) → Skip to C8, Staff Assessment for Mental Status 1. Yes **C2.** Repetition of Three Words: Ask resident: "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." Number of words repeated after first attempt: 0. None 1. One 2. Two 3. Three After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.	**N27A-C:** Is patient oriented to self, place, and time? Memory (FIM item) Problem Solving (FIM item) **N27A.** Is patient oriented to self? (i.e., knows his/her name)? 0. No 1. Yes **N27B.** Is patient oriented to place (i.e. knows he/she is in a rehab setting/hospitals)? 0. No 1. Yes **N27C**. Is patient oriented to time (i.e. the day, month and year)? 0 = No 1 = Yes Memory: Includes skills related to recognizing and remembering while performing daily activities in an institutional or community setting.	**M0560 Cognitive Functioning.** **M0570** When Confused **M0560.** Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.) 0. Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions. 2. Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility. 3. Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.	**C0710. Cognitive Functioning:** (Participant's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.) 0. Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions. 2. Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility. 3. Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. 4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.	**Proposed Item** **B. Brief Interview for Mental Status (BIMS)** **B1.** Interview Attempted? 0. No – Indicate reason (unresponsive, communication disorder, no interpreter available) Skip remaining items in this section and conduct *Observational Assessment* 1. Yes **B2. Repetition of Three Words** Ask patient: "I am going to say 3 words for you to remember. Please repeat the words after I have said all 3. The words are: sock, blue, and bed. Now tell me the 3 words." 3. Three 2. Two 1. One 0. None After the patient's first attempt say: "I will repeat each of the 3 words with a cue: sock, something to wear; blue, a color; bed, a piece of furniture." You may repeat the words up to 2 or more times. **B3. Temporal Orientation** (orientation to year, month, and day) Ask patient: "Please tell me what year it is right now." Patient's answer is: 3. Correct 2. Missed by 1 year 1. Missed by 2-5 years 0. Missed by more than 5 years or no answer

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Brief Interview for Mental Status (continued)	**C3. Temporal Orientation** (orientation to year, month, and day) "Please tell me what year it is right now." a. Able to report correct year 3. Correct 2. Missed by 1 year 1. Missed by 2-5 years 0. Missed by > 5 years or no answer Ask resident: "What month are we in right now?" a. Able to report correct month 2. Accurate within 5 days 1. Missed by 6 days to 1 month 0. Missed by < 1 month or no answer Ask resident: "What day of the week is today?" a. Able to report correct day of the week 1. Correct 0. Incorrect or no answer **C4.** Recall. Ask resident: "Let's go back to the first question. What were those three words that I asked you to repeat?" 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" 2. Yes, no cue required 1. Yes, after cueing ("something to wear") 0. No – could not recall b. Able to recall "blue" 2. Yes, no cue required 1. Yes, after cueing ("a color") 0. No – could not recall c. Able to recall "bed" 2. Yes, no cue required 1. Yes, after cueing ("a piece of furniture") 0. No – could not recall	Memory in this context includes the ability to store and retrieve information, particularly verbal and visual. The functional evidence of memory includes recognizing people frequently encountered, remembering daily routines, and executing requests without being reminded. A deficit in memory impairs learning as well as performance tasks. 7.complete independence 6. modified independence 5. supervision 4. minimal prompting 3. moderate prompting 2. maximal prompting 1. total assistance Problem solving includes skills related to solving problems of daily living. This means making reasonable, safe, and timely decisions regarding financial, social and personal affairs, as well as initiation, sequencing, and self-correcting of tasks and activities to solve problems. 7. complete independence 6. modified independence 5. supervision 4. minimal direction 3. moderate direction 2. maximal direction 1. total assistance	4. Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium When confused (reported or observed): 0. Never 1. In new or complex situations 2. On awakening or at night only 3. During the day and evening, but not constantly 4. constantly NA – Patient nonresponsive	—	Ask patient: "What month are we in right now?" Patient's answer is: 2. Accurate within 5 days 1. Missed by 6 days to 1 month 0. Missed by more than 1 month or no answer Ask patient: "What day of the week is today?" Patient's answer is: 1. Correct 0. Incorrect or no answer **B4**. Recall Ask patient: "Let's go back to the first question. What were those 3 words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture" for that word. Recalls "sock"? 2. Yes, no cue required 1. Yes, after cueing ("something to wear") 0. No, could not recall Recalls "blue"? 2. Yes, no cue required 1. Yes, after cueing ("a color") 0. no, could not recall Recalls "bed"? 2. Yes, no cue required 1. Yes, after cueing ("a piece of furniture") 0. No, could not recall Summary Score (calculated) – score may range from 0 to 15. If 1 or more answers are incorrect, then the Confusion Assessment Method" will be completed. ——————————— For those patients answering 1 or more questions incorrectly on the Brief Interview of Mental Status, the Signs and Symptoms of Delirium (Confusion Assessment Method) will also be completed. If patient is unable to be interviewed for the mental status exam, staff observation items will be used.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Brief Interview for Mental Status (continued)	**C5. Summary Score.** Add scores for questions C2-C4 and fill in total score (00-15). Enter 99 if unable to complete interview. C6. Organized Thinking a. Ask resident; "are there fish in the ocean?" 1. correct ("yes") 0. incorrect or no answer Ask resident "Does one pound weigh more than two pounds?" 1. correct ("no") 0. incorrect or no answer Ask resident: "Can a hammer be used to pound a nail?" 1. correct ("yes") 0. incorrect or no answer	—	—	—	—
Observational Assessment of Cognitive Status	**Staff Assessment for Mental Status –** Complete only if resident interview (C2-**C6)** not completed. **C8.** Short Term Memory OK Seems or appears to recall after 5 minutes **C9.** Long Term Memory OK Seems or appears to recall long past Rating Scale for C8 and C9: 0. Memory OK 1. Memory Problem **C10.** Memory/Recall Ability Check all that the resident was normally able to recall during the last 5 days: a. Current season b. Location of own room c. Staff names and faces d. That he or she is in a nursing home e. None of the above is recalled	No equivalent item.	No equivalent item.	No equivalent item.	**Proposed Item** **C1. Short-Term Memory** Seems or appears to recall after 5 minutes 0. Memory OK 1, Memory problem? 8. Unable to assess **C2. Long-Term Memory** Seems or appears to recall long past 0. Memory OK 1, Memory problem? 8. Unable to assess **C3. Memory/Recall Ability** Check all that the patient normally recalled during the past 2 days a. current season b. location of own room c. staff names and faces d. that he or she is in a hospital (or nursing home or home) e. None of the above is recalled

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Observational Assessment of Cognitive Status (continued)	**C11. Cognitive Skills for Daily Decision Making** Makes decisions regarding tasks of daily life 0. Independent – decisions consistent/reliable 1. Modified independent – some difficulty in new situations only 2. Moderately impaired – decisions poor; cues/supervision required 3. Severely impaired – never/rarely made decision	No equivalent item.	No equivalent item.	No equivalent item.	**C4. Cognitive Skills for Daily Decision Making** Makes decision regarding tasks of daily life last 2 days 0. Independent: decisions consistently reasonable 1. Impaired: some difficulty or decisions poor; supervision required
Confusion Assessment Method	Signs and Symptoms of Delirium Acute onset Mental Status Change **C12. Signs and Symptoms of Delirium (from CAM)** After interviewing the resident, code the following behaviors (a-d) in last 5 days. a. **Inattention** – Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty keeping track of what we said)? b. **Disorganized thinking** – Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? c. **Altered level of consciousness** – did the resident have altered level of consciousness? (e.g., vigilant – startles easily to any sound or touch; lethargic – repeatedly dozes off when being asked questions, but responds to voice or touch; stuporous – very difficult to arouse and keep aroused for the interview; comatose – cannot be aroused)	No equivalent item.	No equivalent item.	No equivalent item.	**Proposed Item** Code the following behaviors at the 2-day assessment period. **D1**. Inattention: the patient has difficult focusing attention? 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity) **D2. Disorganized thinking**: The patient's thinking is disorganized or incoherent? 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity) **D3**. Altered level of consciousness: The patient has an altered level of consciousness (e.g., vigilant, lethargic, stuporous or comatose) 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Confusion Assessment Method (continued)	**d. Psychomotor retardation** – Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly? Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	No equivalent item.	No equivalent item.	No equivalent item.	**D4.** Psychomotor retardation: Resident has an unusually decreased level of activity (e.g., sluggishness, staring into space, staying in one position, moving very slowly) 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)
Behavioral Signs & Symptoms	**E2. Behavioral Symptom** – Presence and Frequency. Note presence of symptoms and their frequency in the last 5 days: 0. Not present in last 5 days 1. Present 1-2 days 2. Present 3 or more days a. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) b. Verbal behavioral symptoms directed towards others (e.g., threatening, screaming at others; cursing at others) c. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as the resident hitting or scratching Self, pacing, rummaging, public sexual acts, disrobing in public, and throwing or smearing food or bodily wasters, or verbal/vocal symptoms like screaming, disruptive sounds.)	**Social Interaction (FIM item)** Social interaction includes skills related to getting along and participating with others in therapeutic and social situations. It represents how one deals with one's own needs together with the needs of others. Examples of socially inappropriate behaviors include temper tantrums; loud, foul or abusive language; excessive laughing or crying; physical attack; or very withdrawn or non-interactive. 7. complete independence 6. modified independence 5. supervision 4. minimal prompting 3. moderate prompting 2. maximal prompting 1. total assistance	**M0610. Behaviors Demonstrated at Least Once a Week** (Reported or Observed): (mark all that apply.) 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required 2. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions 3. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. 4. Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)	C0690. Frequency of Behavior Problems (Reported or Observed): Has the participant exhibited any of the following behaviors over the past six months? (Respond for each item below) a. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. b. Physical aggression: aggressive/combative to self or others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects) c. Disruptive, infantile, regressive, or socially inappropriate behavior (other than above) d. Delirium, confusion, delusional, hallucinatory, or paranoid behavior e. Agitated (pacing, fidgeting, argumentative)	**Proposed Item** **E.** Behavioral Signs and Symptoms Has the patient exhibited any of the following behaviors in the last 2 days? **E1.** Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing): Yes or No **E2.** Verbal behavioral symptoms directed toward others (e.g., threatening, screaming at others) Yes or No **E3.** Other behavioral symptoms not directed at others, including resisting care or self-injurious behaviors (e.g., hitting or scratching self, pacing, attempts to pulling out IVs) Yes or No. If this symptoms is selected, then there may be further questions regarding suicide attempts in the recent past – last 6 months to one year

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Behavioral Signs & Symptoms (continued)	—	—	5. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions) 6. Delusional, hallucinatory, or paranoid behavior 7. None of the above behaviors demonstrated **M0620. Frequency of Behavior Problems** (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.): 0. Never 1. Less than once a month 2. Once a month 3. Several times each month 4. Several times a week 5. At least daily	0. Never 1. Once/month or less 2. Several times a month 3. Several times a week 4 Every day	—
Mood	**D. Self-Rated Mood Interview –** Complete D1-D4 for all residents who are capable of any communication (B5 is 0, 1, or 2), and for whom an interpreter is present or not required. **D1. Interview Attempted?** 0. No (resident is rarely/never understood or needed interpreter not present) 1. Yes **D2. Interview** (From PHQ-9) Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?" I. Symptom Presence If yes, obtain frequency.	**N52.** Score the lowest signs of depression exhibited by the patient within the assessment period *(for admission and discharge separately)* Score using the scale below: 7. No Problem; No evidence of depression. 6. Minimal Problem; Minimal signs of depressed mood. Vegetative signs and cognitive changes attributable to depression are not present. 5. Mild Problem; Mild signs of depressed mood. Vegetative signs and cognitive changes from depression are not present.	**M0590.** Depressive Feelings Reported or Observed in Patient: (Mark all that apply) 1. Depressed mood (e.g., feeling sad, tearful) 2. Sense of failure or self reproach 3. Hopelessness 4. Recurrent thoughts of death 5. Thoughts of suicide 6. None of the above feelings observed or reported	**C0680.** Reported or Observed Depression or Depressive Symptoms and Social Isolation: Has the participant exhibited or expressed any of the following symptoms over the past six months? (Respond for each item below) a. Decreased level of energy and activity b. Slowing of thinking, language, and behavior c. Decrease in appetite d. Expressions of feelings of worthlessness or futility e. Crying spells f. Consistent sadness	Proposed Item F1. Mood Interview Attempted? 0. No 1. Yes **F2. Patient Health Questionnaire 2 (PHQ-2)** Ask patient: "During the last 2 weeks, have you been bothered by any of the following problems?" a. Little interest or pleasure in doing things? 0. No 1. Yes 8. Unable to respond b. If Yes, how many days in the last 2 weeks? 0. Not at all (0 to 1 days) 1. Several days (2 to 6 days) 2. More than half of the days (7 to 11 days) 3. Nearly every day (12 to 14 days)

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Mood (continued)	a. Little interest or pleasure in doing things 0. No 1. Yes 9. No response b. Feeling down, depressed, or hopeless 0. No 1. Yes 9. No response c. Trouble falling or staying asleep, or sleeping too much 0. No 1. Yes 9. No response d. Feeling tired or having little energy 0. No 1. Yes 9. No response e. Poor appetite or overeating 0. No 1. Yes 9. No response f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down 0. No 1. Yes 9. No response g. Trouble concentrating on things, such as reading the newspaper or watching television 0. No 1. Yes 9. No response	4. Mild to Moderate Problem; Mild-moderate signs of depressed mood. Difficulty concentrating. Mild vegetative signs. 3. Moderate Problem; Moderate signs of depressed mood. Vegetative signs and/or cognitive changes from depression or it interferes with/limits functioning. 2. Moderate to Severe problem; Moderate-severe signs of depressed mood. Vegetative signs and/or cognitive changes. Depression interferes with/limits functioning. 1. Severe Problem; Extreme signs of depressed mood, even with interventions. Vegetative signs and/or cognitive changes. Unable to participate meaningfully in treatment. 0. Not assessed. The next 4 items are from the **Geriatric Depression Scale**. Please ask the patient to choose the best answer for how they have felt in the past week. (Check boxes below: Y – Yes N – No) (*This is completed separately for admission and discharge)* **N53A**. Do you feel that your life is empty?	—	g. Sleep disturbances, insomnia, or excessive sleeping h. Recurrent fear of death i. Withdrawn/isolated j. Loneliness 0. Never 1. Once/month or less 2. Several times a month 3. Several times a week 4. Every day	c. Feeling down, depressed, or hopeless? 0. No 1. Yes 8. Unable to respond d. If yes, how many days in the last 2 weeks? 0. Not at all (0 to 1 days) 1. Several days (2 to 6 days) 2. More than half of the days (7 to 11 days) 3. Nearly every day (12 to 14 days) _____ PROMIS items were also considered for the measurement of mood and depression. The items considered are provided below. During the past week, I felt depressed (CES-D #6) 0. rarely or none of the time (less than 1day) 1. Some or a little of the time (1-2 days) 2. Occasionally or a moderate amount of time (3-4 days) 3. Most or all of the time (5-7 days) During the past [*fill in time frame*], I felt hopeless (PROMIS) 1. Never 2. Rarely 3. Sometimes 4. Often 5. Always During the past [*fill in time frame*], I felt sad (PROMIS) 1. Never 2. Rarely 3. Sometimes 4. Often 5. Always

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Mood (continued)	h. Moving or speaking so slowly that other people could have noticed. Or the opposite 0—being so fidgety or restless that you have been moving around a lot more than usual 0. No 1. Yes 9. No response i. Thoughts that you would be better off dead, or of hurting yourself in some way 0. No 1. Yes 9. No response If i = "Yes", check here to indicate that the charge nurse has been informed II. Symptom Frequency. Circle one response 0. 0-1 day (Not at all) 1. 2-6 days (Several days) 2. 7-11 days (More than half the days) 3. 12-14 days (Nearly every day) D3. Total Severity Score Sum of all circled frequency responses (D2-II; items a-i). Score may be between 00 and 27. Enter 99 if unable to complete interview (3 or more items in column I marked "No response") Check here if some or all frequency responses (D2-II; items a-i) are missing from total score.	(Score 53B through 53D only if item 53A is Yes. Count the number of shaded boxes – A through D – and code total score in E): **N53B.** Are you basically satisfied with your life? (shaded box = no) **N53C.** Are you afraid that something bad is going to happen to you? (shaded box = yes) **N53D.** Do you feel happy most of the time? (shaded box = no) **N53E.** Total Depression Score (one point for each shaded box) Sum of N53A-N53D, at admission and discharge separately **N53F**. Can the patient answer the prior questions? **N54**. Was the patient referred to a mental health professional for assessment for any reason?	—	—	—

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Sad	No equivalent item.	No equivalent item.	No equivalent item.	No equivalent item	Proposed Item F3. During the past 2 weeks, how often would you say "I feel sad"? 1. Never 2. Rarely 3. Sometimes 4. Often 5. Always 8. Unable to respond This item is a self-report item from the PROMIS database. It is important for understanding patient mood which can predict resource use and outcomes.
Pain	**Pain Assessment Interview** – All residents should be asked about pain. Complete J2-J7 for all residents who are capable of any communication (B5 is coded 0, 1, or 2), and for whom an interpreter is present or not required. **J2. Interview Attempted?** 0. No (resident is rarely/never understood or needed interpreter is not present) → Skip to J9, Staff Assessment of Pain 1. Yes **J3. Pain presence** Ask resident: "Have you had pain or hurting at any time in the last 5 days?" 0. No → Skip to J8, Interview Completed 1. Yes → Proceed to items J4-J8 below 9. Unable to answer → Skip to J8, Interview Completed	**50A.** Rate the highest level of pain reported by patient within the assessment period (*at admission and discharge, separately)* (Score using the scale below; report whole numbers only) 0 (No pain) 1 2 3 4 5 (moderate pain) 6 7 8 9 10 (Worst possible pain)	**M0420.** Frequency of pain interfering with patient's activity or movement: 0. Patient has no pain or pain does not interfere with activity or movement 1. Less often than daily 2. Daily, but not constantly 3. All of the time **M0430.** Intractable pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity? 0. No 1. Yes	**Participant Pain:** If participant has pain in multiple locations, respond based on the most severe or intrusive pain. **C0270_1**. Has the participant experienced Any Pain in the past week? 0. No [If No, go to C0280_1] 1. Yes **C0270_2.** Severity of Pain: How would the participant rate his/her worst pain in the past week, on scale of 1 to 10? (circle rating) (Minimal Pain) 1 2 3 4 5 6 7 8 9 10 (Extreme Pain)	**Proposed Item** **G1. Pain Interview Attempted?** 0. No 1. Yes **G2 Pain Presence.** Ask patient: "Have you had pain or hurting at any time during the last 2 days?" 0. No 1. Yes. 8. Unable to answer or no response **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. **G4. Pain Severity.** Ask patient: "Please rate the intensity of your worst pain during the last 2 days." 1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 8. Unable to answer or no response G5a. Pain Effect on Function. Ask patient: "During the past 2 days, has pain made it hard for you to sleep at night?"

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Pain (continued)	**J4. Pain Frequency** Ask resident: "How much of the time have you experienced pain or hurting over the last 5 days?" 1. Almost constantly 2. Frequently 3. Occasionally 4. Rarely 9. Unable to answer **J5. Pain Effect on Function** a. Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?" 0. No 1. Yes 9. Unable to answer b. Ask resident: "Over the past 5 days, have you limited your day-to-day activities because of pain?" 0. No 1. Yes 9. Unable to answer **J6. Pain intensity** – Administer one of the following pain intensity questions (a or b) a. Verbal Descriptor Scale Ask resident: "Please rate the intensity of your worst pain over the last 5 days" (Show resident verbal scale.) 1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 9. Unable to answer or not attempted b. Numeric Rating Scale (00-10) Ask resident:	—	—	**C0270_3.** Frequency of Pain (in the past week): 1. Less often than daily 2. Daily, but not constantly 3. All of the time **C0270_4.** Pain Interfering with Daily Activities: In the past week, how often has pain gotten in the way of participant's normal routine? (NOTE: If the participant's level of pain has changed in the past week, answer should be based on the most recent level of pain.) 1. Pain does not get in the way of normal routine 2. At times, but not every day 3. Every day, but not constantly 4. All of the time **C0270_5.** Intractable Pain: Is the participant experiencing pain that is not easily relieved, occurs at least daily, and affects the participant's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity? 0. No 1. Yes	0. No 1. Yes 8. Unable to answer or no response **G5b.** 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. _____ PROMIS items were also considered for the measurement of pain. The items considered are provided below. Please rate your pain by selecting the one number that best describes your pain at its worst (Brief Pain Inventory #12) 0-10 Please rate your pain by selecting the one number that best describes your pain right now (Brief Pain Inventory #15) 0-10 How much does your pain interfere with your daily activities? (PROMIS) 1. Not at all 2. A little bit 3. Somewhat 4. Quite a bit 5. Very much

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Pain (continued)	"Please rate your worst pain over the last 5 days on a zero to ten scale with zero being no pain and ten as the worst pain you can imagine" (Show resident 0-10 pain scale) Enter two-digit response. Enter 99 if unable to answer or not attempted. c. Indicate which Pain Intensity question was administered. 1. Verbal Descriptor Scale only 2. Numeric Rating Scale (00-10) only 3. Both were tried and one scale completed 9. Both were tried, and neither scale completed. **J7. Pain Treatment Goals** Ask resident: "In your opinion, how important is it for your pain treatment to completely eliminate your pain?" 1. Extremely important 2. Very important 3. Somewhat important 4. Not at all important 9. Unable to answer **J8. Skip Item: Interview Completed** 0. No (Resident was unable to answer whether pain was present in J3, or unable to answer 3 or more pain descriptors in items J4-J7) → Proceed to J9, Staff Assessment for Pain 1. Yes → Skip to J10, Shortness of Breath **J1. Pain Management** (answer for all residents, regardless of current pain level) At any time in the last 5 days, has the resident: a. Been on a scheduled pain medication regimen? 0. No 1. Yes	—	—	—	—

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Pain (continued)	b. Received PRN pain medications? 0. No 1. Yes c. Received non-medication intervention for pain? 0. No 1. Yes **J7. Pain Treatment Goals** Ask resident: "In your opinion, how important is it for your pain treatment to completely eliminate your pain?" 1. extremely important 2. very important 3. somewhat important 4. not at all important 9. unable to answer	—	—	—	—
Pain Observational Assessment	**J9. Staff Assessment for Pain** – Complete only if pain interview (J2-J8) not completed Indicators of pain or possible pain in the last 5 days. Check all that apply: a. Non-verbal sounds (crying, whining, gasping, moaning, or groaning) b. Vocal complaints of pain (that hurts, ouch, stop) c. Facial expressions (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) d. Protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement) e. None of these signs observed or documented.	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **G6. Pain Observational Assessment.** Check all indicators of pain or possible pain at the 2-day assessment period. **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 movement 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

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
V. Impairments	—	—	—	—	—
Impairments	No equivalent item.	No equivalent item.	No equivalent item.	No equivalent item.	Proposed Item A1. Does the patient have any impairments in bladder or bowel management, hearing, vision, communication, range of motion, weight-bearing, grip strength, respiratory status, or endurance? 0. No 1. Yes
Bladder and Bowel Management	**H1. Urinary Appliances** (check all that applied in last 5 days) a. Indwelling bladder catheter b. External (condom) catheter c. Ostomy (suprapubic catheter, ileogstomy) d. Intermittent catheterization e. None of the above _____ **H2. Urinary Continence.** Urinary continence in last 5 days. Select the one category that best describes the resident over the last 5 days. 0. Always continent 1. Occasionally incontinent (less than 5 episodes of incontinence) 2. Frequently incontinent (5 or more episodes of incontinence but at least one episode of continent voiding) 3. Always incontinent (no episodes of continent voiding) 9. Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 5 days	**30. Bladder Frequency of Accidents** 7. No accidents 6. No accidents, uses device such as a catheter 5. One accident in the past 7 days. 4. Two accidents in the past 7 days. 3. Three accidents in the past 7 days. 2. Four accidents in the past 7 days. 1. Five or more accidents in the past 7 days. _____ **32. Bowel Frequency of Accidents** 7. No accidents 6. No accidents, uses device such as a catheter 5. One accident in the past 7 days.	**M0520. Urinary Incontinence or Urinary Catheter Presence.** 0. No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1. Patient is incontinent 2. Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) _____ **M0520. Urinary Incontinence.** When does Urinary Incontinence occur? 0. Timed-voiding defers incontinence 1. During the night only 2. During the day and night	**C0440_1. Bladder Continence.** Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants). 0. Continent – Complete control 1. Usually continent, incontinence episodes once a week or less 2. Occasionally incontinent, 2+ times a week but not daily 3. Frequently incontinent, tends to be incontinent daily, but some control present 4. Incontinent – Has inadequate control, multiple daily episodes 5. Participant has catheter _____ **C0440_2. Urinary Incontinence**. When does Urinary Incontinence occur? 0. Timed-voiding defers incontinence 1. During the night only 2. During the day and night	**Proposed Item:** **B1.** Does this patient use an external or indwelling device or require intermittent catheterization? 0. No 1. Yes **B2.** Indicate the frequency of incontinence during the 2-day assessment period. 0. Continent (no documented incontinence) 1. Stress incontinence only (bladder only) 2. Incontinent less than daily (only once during the 2-day assessment period) 3. Incontinent daily (at least once a day) 4. Always incontinent 5. No urine/bowel output during the 2-day assessment period (e.g., renal failure) **B3.** 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)? 0. No 1. Yes

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Bladder and Bowel Management (continued)	**H4. Bowel Continence**. Bowel continence in last 5 days. Select the one category that best describes the resident over the last 5 days. 0. Always continent 1. Occasionally incontinent (less than 5 episodes of incontinence) 2. Frequently incontinent (5 or more episodes of incontinence but at least one episode of continent voiding) 3. Always incontinent (no episodes of continent voiding) 9. Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 5 days	4. Two accidents in the past 7 days. 3. Three accidents in the past 7 days. 2. Four accidents in the past 7 days. 1. Five or more accidents in the past 7 days. **39G/H. Sphincter Control**. Bladder and bowel sphincter control at admission, discharge and goal. 7. Complete Independence (Timely, Safely) 6. Modified Independence (Device) 5. Supervision (Subject=100%) 4. Minimal Assistance (Subject=75% or more) 3. Moderate Assistance (Subject=50% or more) 2. Maximal Assistance (Subject=25% or more) 1. Total Assistance (Subject less than 25%) 0. Activity does not occur: Use this code only at admission.	**M0540. Bowel Incontinence. Frequency.** 0. Very rarely or never has bowel incontinence 1. Less than once weekly 2. One to three times weekly 3. Four to six times weekly 4. On a daily basis 5. More often than once daily NA. Patient has ostomy for bowel elimination UK. Unknown **M0550. Ostomy for Bowel Elimination.** Does this patient have an ostomy for bowel elimination that (within the last 14 days) a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen? 0. Patient does not have an ostomy for bowel elimination 1. Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen 2. The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.	**C0460. Bowel Incontinence. Frequency:** 0. Very rarely or never has bowel incontinence 1. Less than once weekly 2. One to three times weekly 3. Four to six times weekly 4. On a daily basis 5. More often than once daily NA. Participant has ostomy for bowel elimination	**B4.** If the patient is incontinent or has an indwelling catheter, does the patient have a history of incontinence (excluding stress incontinence) prior to the current illness, exacerbation, or injury? 0. No 1. Bladder only 2. Bowel only 3. Bladder and bowel 9. Unknown _____ • History of incontinence may be difficult to capture but is important to know for predicting/measuring outcomes. • The existence of a device for incontinence as well as the need for assistance in the care of these devices provides information for measuring outcomes and resource utilization. • Similarly the frequency of incontinence questions provides additional information about potential levels of resource utilization.
Swallowing	**K1. Swallowing Disorder**. Signs and symptoms of possible swallowing disorder. Check all that applied in last 5 days: a. Loss of liquids/solids from mouth when eating or drinking b. Holding food in mouth/cheeks or residual food in mouth after meals	**27. Swallowing Status.** 3. Regular food: solids and liquids swallowed safely without supervision or modified food consistency 2. Modified food consistency/supervision: subject requires modified food consistency and/or needs supervision for safety.	—	—	**Proposed Item** **C1**. Swallowing Disorder: Signs and symptoms of possible swallowing disorder. Check all that apply. C1a. No signs or symptoms of a possible swallowing disorder **C1b.** Complaints of difficulty or pain with swallowing

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Swallowing (continued)	c. Coughing or choking during meals or meals or when swallowing medications d. Complaints of difficulty or pain with swallowing e. None of the above	1. Tube/Parenteral Feeding: tube/parenteral feeding used wholly or partially as a means of sustenance.	No equivalent item.	No equivalent item.	**C1c.** Coughing or choking during meals or when swallowing medications. C1d. Holding food in mouth/cheeks or residual food in mouth after meals **C1e.** Loss of liquids/solids from mouth when eating or drinking **C1f.** NPO: intake not by mouth **C1g.** Other (specify) C2. Swallowing: Describe the patient's usual ability with swallowing. a. Regular food: Solids and liquids swallowed safely without supervision and without modified food or liquid consistency. b. Modified food consistency/supervision: Patient requires modified food or liquid consistency and/or needs supervision during eating for safety. c. Tube/parenteral feeding: Tube/parenteral feeding used wholly or partially as a means of sustenance.
Communication and Comprehension	**B5. Makes Self Understood** Ability to express ideas and wants, consider both verbal and non-verbal expression in last 5 days. 0 = Understood – clear comprehension 1 = Usually understood – difficulty communicating some words or finishing thoughts but if given time or some prompting is able 2 = Sometimes understood – ability is limited to making concrete requests 3 = Rarely/never understands	**39N. Comprehension** Mode: A – Auditory/V-Visual/B-Both **39O. Expression** Mode: V-Vocal/N-Nonvocal/B-Both FIM levels *No Helper* 7 = Complete Independence (Timely, Safely) 6 = Modified Independence (Device) *Helper – Modified Dependence* 5 = Supervision (Subject = 100%)	**M0400.** Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them): 0 = No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation. 1 = With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice. 2 = Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.	**C0740.** Ability to understand others in participant's primary language (understanding information content – however able; e.g., understanding spoken language, sign language, writing, or other means): 0 = No observable impairment. Understands complex or detailed instructions and participates normally in conversation. 1 = With mild difficulty, understands one-step instructions and simple multi-step instructions. Able to participate in ordinary conversation. 2 = Has moderate difficulty understanding simple, one-step instructions and participating in conversation; may need frequent prompting or assistance	**Proposed Item** **D1. Understanding verbal content (**with hearing aid or device if used) 3. Understands: clear comprehension without cues or repetitions 2. Usually/Sometimes Understands: comprehends only basic conversations or simple, direct phrases or requires cues to understand 1. Rarely/Never Understands 8. Unable to assess 9. Unknown **D2. Expression of ideas and wants.** 3. Expresses complex messages without difficulty and with speech that is clear and easy to understand 2. Exhibits difficulty with expressing needs and ideas or speech is not clear 1. Rarely/Never expresses self or speech is very difficult to understand 8. Unable to assess 9. Unknown

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Communication and Comprehension (continued)	**B6. Ability to Understand Others** Understanding verbal content, however able (with hearing aid or device if used) in last 5 days. 0 = Understands – clear comprehension 1 = Usually understands – misses some part/intent of message BUT comprehends most conversation 2 = Sometime understands – responds adequately to simple, direct communication only 3 = Rarely/never understands	4 = Minimal Assistance (Subject = 75% or more) 3 = Moderate Assistance (Subject = 50% or more) *Helper – Complete Dependence* 2 = Maximal Assistance (Subject = 25% or more) 1 =Total Assistance (Subject less than 25%) 0 = Activity does not occur; Use this code only at admission	—	3 = Has severe difficulty understanding simple instructions and conversation. May require multiple repetitions, restatements, demonstrations 4 = Unable to understand even simple language C0570. Ability to Express Thoughts, Wants, Needs in primary language (expressing information content – however able; e.g., using spoken language, sign language, writing, or other means): 0 = No observable impairment. Able to express complex ideas, feelings, and needs clearly, completely, and easily in most situations 1 = Has mild difficulty in expressing ideas and needs (choice of words, word order, or grammar may sometimes be unclear or confusing; may need minimal prompting or assistance). 2 = Has moderate difficulty in expressing simple ideas or needs (choice of words, word order, or grammar commonly unclear or confusing; needs prompting or assistance) 3 = Has severe difficulty in expressing basic ideas or needs and requires considerable assistance 4 = Unable to express basic needs even with considerable prompting or assistance (e.g., communication is nonsensical or unintelligible)	—

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Hearing and vision	**B2. Hearing** Ability to hear (with hearing aid or hearing appliance if normally used) last 5 days. 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 **B7. Vision** Ability to see in adequate light (with glasses or other visual appliances) in last 5 days. 0 = Adequate – sees find detail, including regular print in newspapers/books 1 = Impaired – sees large print, but not regular print in newspapers/books 2 = Moderately impaired – limited vision; not able to see newspaper headlines but can identify objects 3 = Highly impaired – object identification	—	M0400. Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them): 0 = No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation. 1 = With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice. 2 = Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance. 3 = Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time. 4 = Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive.	C0370. Hearing. How well the participant hears, with a hearing aid if one is customarily worn. When a participant has a hearing aid, but does not usually wear it, base rating on how well he or she hears without the hearing aid. Assess participant's level of impairment, with hearing aid, if used on a regular basis. 0 = No Impairment. Hears adequately in most situations (with a hearing aid, if customarily worn) 1 = Partial Impairment - Has difficult hearing; speaker must raise voice and/or repeat phrases in order to be heard. - Hears well in some situations, but not in others. Example: Participant hears well in a quiet setting, but has difficulty when there is background noise, e.g., in a room where other conversations are taking place. - Hears some voices well, but has difficulty hearing certain voices. 2 = Total Impairment - Cannot hear at all, even with corrective device. - Hearing is so poor that participant does not hear speech, even with repeated efforts by the person speaking.	**Proposed Item** **D3. Ability to see in adequate light** (with glasses or other visual appliances) 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 **D4 Ability to hear** (with hearing aid or hearing appliance if normally used) 3. Adequate: hears normal conversation and TV without difficulty Mildly to Moderately Impaired: difficulty hearing in some environment or speaker may need to increase volume or speak distinctly. 1. Severely Impaired: absence of useful hearing 8. Unable to assess 9. Unknown.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Hearing and Vision (continued)	—	—	M090. Vision with corrective lenses if patient usually wears them: 0 = Normal vision: sees adequately in most situations; can see medication labels, newsprint 1 = Partially impaired: cannot see medication labels or newsprint , but can see obstacles in path, and the surrounding layout; can count fingers at arm's length 2 = Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.	C0360. Vision: How well the participant sees in good light, with corrective lenses if customarily worn. When a participant has glasses, but does not wear them, base rating on how well he or she sees without glasses. Assess participant's level of impairment, with corrective device, if used on a regular basis. 0 = No Impairment. - Has adequate near and distant vision in all or most situations, in good light; does not complain of visual fatigue or difficulty reading or distinguishing objects. - Able to read newsprint or see fine detail and able to read a wall clock or see objects at a reasonable distance. - Uses a magnifying glass (or non-prescription magnifying glasses) to read, reads without difficulty, and has adequate distant vision 1 = Partial Impairment - Can read and/or see fine detail, but has difficulty with distant vision (i.e., is near-sighted) - Has difficulty reading newsprint or seeing fine detail, but is able to see objects at a reasonable distance (i.e., is far-sighted) - Has difficulty reading and with distant vision, but sees well enough to get around safely (e.g., can see obstacles in path). - Can count fingers at arm's length	—

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Hearing and Vision (continued)	—	—	—	2 = Total Impairment - Cannot see at all, even with corrective device - Sees some light or shadows, but vision is so poor that participant is not able to see obstacles in his/her path	—
Upper Extremity Range of Motion	G4-Functional limitation in range of motion a) lower extremity (hip, knee, ankle, foot) b) Upper extremity (shoulder, elbow, wrist, hand) 0=No impairment; 1=Impairment on one side; 2=Impairment on both sides;	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **E. Upper Extremity Range of Motion.** Indicate if the patient has functional range of motion within normal limits in the following joints: **E1a.** Left shoulder **E1b.** Left elbow **E1c.** Right shoulder **E1d.** Right Elbow Coding: 1. Within Normal Limits: Range of motion is within normal limits. 0. Limited Range of Motion: Patient's range of motion is not within normal limits.
Weight-bearing	No equivalent item	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **F. Weight-bearing.** Indicate if the patient has weight-bearing restrictions in the following extremities: F1a. Upper Extremity (Left) F1b. Upper Extremity (Right) F1c. Lower Extremity (Left) F1d Lower Extremity (Right) Coding: Indicate all the patient's weight-bearing restrictions in the 2-day assessment period. 1. Fully weight bearing: No medical restrictions 0. Not fully weight-bearing: Patient has medical restrictions. _____ • Weight bearing will be important to capture in the core items because it is related to the ability use assistive devices and the ability to perform surface-to-surface transfers. • The rating scale for the weight-bearing items will be dichotomous indicating that the patient is full weight-bearing or that the patient has restrictions. • The item will be measured for right arm/right leg, left arm/left leg, and sitting. • Predicting payments, outcomes, and discharge placement

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Grip Strength	No equivalent item	No equivalent item	No equivalent item	No equivalent item	Proposed Item G. Indicate the patient's ability to squeeze your hand. G1a. Left Hand G1b. Right Hand Coding: Indicate the patient's ability to squeeze your hand in the 2-day assessment period. 2. Normal 1. Reduced/Limited 0. Absent
Respiratory Status	**J10. Shortness of Breath** (dyspnea) Select all that apply in last 5 days. a. Shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring) b. Shortness of breath or trouble breathing when sitting at rest c. Shortness of breath or trouble breathing when lying flat d. None of the above J11. Cough Present Cough present in last 5 days. 0. No 1. Yes	**48.** Shortness of breath with exertion. 0. No 1. Yes _____ **49.** Shortness of breath at rest. 0. No 1. Yes _____ **50.** Weak cough and difficulty clearing airway secretions. 0. No 1. Yes	**M0490: Short of Breath.** When is the patient dyspenic or noticeably short of breath? 0. Never, patient is not short of breath; 1. When walking more than 20 feet, climbing stairs 2. With moderate exertion (e.g. while dressing, using commode or bedpan, walking distance less than 20 feet) 3. With minimal exertion (e.g. while eating, talking, or performing other ADLs) or with agitation 4. At rest (during day or night)	**C0420. Dyspnea.** When is the participant dyspneic or noticeably short of breath? 0. Never, participant is not short of breath 1. When walking more than 20 feet, climbing stairs 2. With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet) 3. With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation 4. At rest (during day or night)	**Proposed Item** **H. Respiratory Status:** Was the patient dyspneic or noticeably short of breath in the 2 day assessment period? 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)

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Endurance	—	—	—	**C0840 Endurance:** Identify the participant's ability to complete routine activities because of limitations of stamina, endurance, shortness of breath or pain. 0=Has adequate stamina/endurance to complete tasks within reasonable time frame. Does not need to take rest breaks and does not become extraordinarily weakened or tired after completing tasks; 1=Has slightly limited stamina/endurance to complete tasks but is able to do so within a reasonable time frame. Needs rest periods and becomes slightly tired or weakened when tasks completed; 2=Has limited physical stamina/endurance to complete tasks and may take considerably longer periods of time to complete tasks. Even with frequent rest breaks becomes very tired or weakened when tasks are completed. Must rest for long periods after any exertion. 3=Does not have the physical stamina to complete tasks. Even with frequent rest cannot complete tasks.	**Proposed Item** **I1. Mobility Endurance:** Did the patient have to stop and rest two or more times when walking or wheeling 50 feet (15 meters) in the 2-day assessment period? **I2. Sitting Endurance:** Was the patient able to tolerate sitting at the edge of the bed for 3 minutes in the 2-day assessment period? 0. No 1. Yes 8. Not assessed

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
VI. Functional status	—	—	—	—	—
Eating and Feeding	**G.1.j=**Eating includes eating, drinking (regardless of skill) or intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids for hydration). **0. Independent**-resident completes activity with no help or oversight; **1. Set up assistance**; **2. Supervision**-oversight, encouragement or cueing provided throughout the activity; **3. Limited assistance**-guided maneuvering of limbs or other non-weight bearing assistance provided at least once; **4. Extensive assistance, 1 person assist**-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once; **5. Extensive assistance, 2+person assist**-resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once;	**39.A Eating** Eating includes the ability to use suitable utensils to bring food to the mouth, as well as the ability to chew and swallow the food once the meal is presented in the customary manner on a table or tray. The patient performs this activity safely. No Helper 7 Complete Independence (Timely, Safely); 6 Modified Independence (Device); Helper-Modified Dependence 5 Supervision (Subject=100%); 4 Minimal Assistance (Subject=75% or more); 3 Moderate Assistance (Subject=50% or more);	**M0710 Feeding or Eating:** Ability to feed self meals and snacks. Note: this refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten. 0-Able to independently feed self; 1-Able to feed self independently but requires: (a) meal set-up OR (b)intermittent assistance or supervision from another person OR (c) a liquid pureed or ground meat diet. 2-Unable to feed self and must be assisted or supervised throughout the meal/snack. 3-Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.	**C0920-Feeding or Eating:** Performance (what participant actually does) to safely feed self meals and snacks. Note: this refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten. 0-Feeds/eats independently Feeds self/eats without any assistance or supervision all of the time. 1-Feeds/eats independently but receives some human assistance or uses assistive device Feeds self independently but requires: (a) meal set-up OR (b)intermittent assistance or supervision (e.g., cueing) from another person OR (c) an assistive device (e.g., utensil with built-up handle, plate guard, or cup with spout to prevent spilling) OR a liquid pureed or ground meat diet.	**Proposed 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 once they are presented to the patient. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent** - Patient completes the activity by him/her self with no assistance from a helper. **4. Supervision/Touching Assistance**-Helper provides VERBAL CUES OR TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. **5. Setup or Clean-up Assistance** – Helper SETS UP OR CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Eating and Feeding	**6. Total dependence, 1 person assist**-full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist**-full staff performance of activity (requiring 2 or more person assistance at least once. The resident must be unable or unwilling to perform any part of the activity. **8. Activity did not occur** during entire period.	Helper-Complete Dependence 2 Maximal Assistance (Subject = 25% or more); 1 Total Assistance (Subject less than 25%); 0=Activity does not occur; Use this code only at admission	4-Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy; 5-Unable to take in nutrients orally or by tube feeding. UK=Unknown.	2-Does not feed/eat independently and receives constant human assistance Must be assisted or supervised throughout the meal/snack. 3-Takes in nutrients orally and by tube feeding Takes in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4-Completely dependent on nasogastric tube or gastrostomy or other artificial opening to the GI tract Does not take nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy or other artificial opening to the GI tract. 5-Does not take in nutrients orally or by tube feeding Receives total parenteral nutrition (TPN).	**3. Partial/Moderate** Assistance-Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but less than half of the time. **2. Substantial/Maximal Assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent** - Helper does ALL of the effort . Person does none of the effort to complete the task. If activity was not attempted code: _____ • The group recommends that a separate tube feeding item also be included. A patient that can manage the tube themselves is considered independent. • If a patient eats by mouth and tube then both items will be completed. • The tube item will is separate from the swallowing item. • Eating excludes meal preparation. • Goals: • Predicting payments, outcomes, and discharge placement.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Oral Hygiene	**G1.k Grooming/personal hygiene** includes combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands (excludes bath/shower). 0. Independent-resident completes activity with no help or oversight; 1. Set up assistance; 2. Supervision-oversight, encouragement or cueing provided throughout the activity; 3. Limited assistance-guided maneuvering of limbs or other non-weight bearing assistance provided at least once; 4. Extensive assistance, 1 person assist-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once;	**39.B Grooming** includes oral care, hair grooming (combing or brushing hair), washing the hands, washing the face, and either shaving the face or applying make-up. If the subject neither shaves nor applies make-up, Grooming includes only the first four tasks. The patient performs this activity safely. This item includes obtaining articles necessary for grooming. No Helper 7 Complete Independence (Timely, Safely); 6 Modified Independence (Device); Helper-Modified Dependence 5 Supervision (Subject=100%); 4 Minimal Assistance (Subject=75% or more); 3 Moderate Assistance (Subject=50% or more);	**M0640 Grooming:** Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or makeup, teeth or denture care, fingernail care) 0-Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1-Grooming utensils must be placed within reach before able to complete grooming activities. 2-Someone must assist the patient to groom self. 3-Patient depends entirely upon someone else for grooming needs. UK-Unknown	**C0880 Grooming: Performance** (what participant actually does) to safely tend to personal hygiene needs (e.g., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care). 0-Grooms independently Does all grooming activities independently, without assistance or supervision, all of the time. 1-Grooms self but receives some human assistance or uses assistive device. Grooms self, but requires assistive device, Does some (but not all) grooming activities independently and receives assistance from others (e.g., shampooing), Grooming utensils (e.g., comb, toothbrush, razor) must be placed within reach to complete grooming activities.	**Proposed Item** **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. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent** - Patient completes the activity by him/her self 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/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 less than half of the time.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Oral Hygiene (continued)	**5. Extensive assistance, 2+person assist**-resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once; **6. Total dependence**, **1 person assist**-full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist**-full staff performance of activity (requiring 2 or more person assistance at least once. The resident must be unable or unwilling to perform any part of the activity. 8**. Activity did not occur** during entire period.	Helper-Complete Dependence 2 Maximal Assistance (Subject = 25% or more); 1 Total Assistance (Subject less than 25%); 0=Activity does not occur; Use this code only at admission; Use this code only at admission	—	2-Grooms self but receives constant human assistance. Participant grooms self if constantly receiving human assistance. 3-Completely dependent All grooming activities are done by another person all of the time.	**2. Substantial/Maximal Assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent** - Helper does ALL of the effort . Person does none of the effort to complete the task. _____ • The team recommends that personal hygiene be limited to oral hygiene rather than also including combing hair, washing, shaving, and applying make-up. • Oral care is something that every patient needs to perform. Even patients without teeth need to take care of dentures and gums. The specificity of this item avoids confounding factors. **Goals:** Predicting payments, outcomes, and discharge placement.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Toilet Hygiene	**G.1.D Toileting** using toilet room (or commode, bed pan, urinal); cleaning self after toileting or incontinent episode(s), changing pad, managing ostomy or catheter, adjusting clothes (excludes toilet transfer). **0. Independent**-resident completes activity with no help or oversight; **1. Set up assistance**; **2. Supervision-oversight,** encouragement or cueing provided throughout the activity; **3. Limited assistance**-guided maneuvering of limbs or other non-weight bearing assistance provided at least once; **4. Extensive assistance, 1 person assist**-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once;	**39.F Toileting:** Toileting includes maintaining perineal hygiene and adjusting clothing before and after using a toilet, commode, bedpan, or urinal. The patient performs this activity safely. No Helper 7 Complete Independence (Timely, Safely); 6 Modified Independence (Device); Helper-Modified Dependence 5 Supervision (Subject=100%); 4 Minimal Assistance (Subject=75% or more); 3 Moderate Assistance (Subject=50% or more); Helper-Complete Dependence 2 Maximal Assistance (Subject = 25% or more); 1 Total Assistance (Subject less than 25%);	**M0680 – Toileting**: ability to get to and from toilet or bedside commode. 0-Able to get to and from toilet independently, with or without a device. 1-When reminded, assisted, or supervised by another person, able to get to and from the toilet. 2-Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3-Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. 4-Is totally dependent in toileting. UK=Unknown.	**C0910-Toileting**: Performance (what the participant actually does) to safely get to and from the toilet or bedside commode, get on and off toilet, clean self and adjust clothes. 0-Toilets independently Gets to and from toilet independently, toilets self without assistive devices or human assistance/supervision, all of the time. 1-Toilets with assistive device Gets to and from the toilet and toilets self with assistive devices (e.g., grab bars, raised toilet seat), but without human assistance. 2-Toilets with some human assistance Gets to and from toilet when reminded, assisted or supervised by another person, may also use assistive device, does part of the toileting, but receives assistance for other parts of the activity (e.g., to get to the toilet room, clean self).	**Proposed Item** **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. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent -** Patient completes the activity by him/her self 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/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 less than half of the time.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Toilet Hygiene (continued)	**5. Extensive assistance, 2+person assist**-resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once; **6. Total dependence, 1 person assist**-full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist-full** staff performance of activity (requiring 2 or more person assistance at least once. The resident must be unable or unwilling to perform any part of the activity. 8. Activity did not occur during entire period.	0=Activity does not occur; Use this code only at admission	—	3-Toilets with constant human assistance or uses bedside commode Requires constant human assistance OR does not go to and from toilet but uses a bedside commode (with or without assistance). 4-Uses bedpan/urinal Does not go to and from toilet but uses a bedpan/urinal independently. 5-Completely dependent Receives physical assistance for all toileting activities, i.e., does not do any of the toileting activities independently any of the time.	**2. Substantial/Maximal Assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent** - Helper does ALL of the effort . Person does none of the effort to complete the task. _____ • A patient who can manage ostomy, catheter, or pad themselves should be considered independent. **Goals:** Predicting payments, outcomes, and discharge placement.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Upper Body Dressing	**G.1.h Dressing upper body dressing** and undressing above the waist, includes prostheses, orthotics, fasteners, pullovers. **0. Independent-**resident completes activity with no help or oversight; **1. Set up assistance;** **2. Supervision-oversight**, encouragement or cueing provided throughout the activity; **3. Limited assistanc**e-guided maneuvering of limbs or other non-weight bearing assistance provided at least once; **4. Extensive assistance, 1 person assist**-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once;	**39.D Dressing Upper Body** includes dressing and undressing above the waist, as well as applying and removing a prosthesis or orthosis when applicable. The patient performs this activity safely No Helper 7 Complete Independence (Timely, Safely); 6 Modified Independence (Device); Helper-Modified Dependence 5 Supervision (Subject=100%); 4 Minimal Assistance (Subject=75% or more); 3 Moderate Assistance (Subject=50% or more); Helper-Complete Dependence 2 Maximal Assistance (Subject = 25% or more);	**M0650 – Ability to Dress Upper Body:** (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons and snaps. 0-Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1-Able to dress upper body without assistance if clothing laid out or handed to patient. 2-Someone must help patient put on upper body clothing. 3-Patient depends entirely upon another person to dress the upper body. UK-Unknown	**C0890-Dressing Upper Body: Performance** (what participant actually does) to safely dress upper body including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps. 0-Dresses independently Gets clothes out of closets and drawers, puts them on and removes them from the upper body without assistance or supervision, all of the time. 1-Dresses self but uses assistive devices or receives some human assistance	**Proposed Item** **A5. Upper Body Dressing:** The ability to put on and remove shirt such as a pajama jacket. Includes buttoning and unbuttoning 3 buttons. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent -** Patient completes the activity by him/her self 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/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 less than half of the time.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Upper Body Dressing (continued)	**5. Extensive assistance, 2+person assist**-resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once; **6. Total dependence, 1 person assist**-full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist**-full staff performance of activity (requiring 2 or more person assistance at least once. The resident must be unable or unwilling to perform any part of the activity. **8. Activity did not occur** during entire period.	1 Total Assistance (Subject less than 25%);. 0=Activity does not occur; Use this code only at admission	—	2-Dresses self with assistive devices (e.g., velcro fasteners on clothing, adaptive clothing and special equipment such as a reacher), dresses upper body without assistance if clothing is laid out or handed to the participant, does part of dressing but receives assistance for other parts of the activity (e.g., to put on or take off some items of clothing, manage fasteners), dresses or undresses self some of the time and receives assistance at other times. 3-Dresses self but receives constant human assistance Receives stand-by supervision for safety, someone must help the participant put on upper body clothing. 4-Completely dependent Patient depends entirely upon another person to dress the upper body all of the time.	2**. Substantial/Maximal Assistance** –Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent** - Helper does ALL of the effort . Person does none of the effort to complete the task. _____ • Upper body mobility is a very important concept to capture in the core set of items. • Upper body dressing is one way to measure upper body mobility but it is difficult to measure consistently across settings due to variation in the type of clothing that patients wear (hospital gown, shirts with buttons, sweatshirts, robes, etc.) • Some clothing is easier to put on than others. Unless the type of clothing is specified, patients with easier clothing will be scored higher compared to patients with more difficult clothing. This may be acceptable because it may signal adaptation to the environment and patients scoring higher have a lower burden of care. But it may not be acceptable to have so much variation in the definition of the item. This would make it impossible to compare. • Undressing is considered to be easier than dressing so it is not included in the item. • Alternative upper body mobility items include brushing hair; washing/drying hands; reaching above head; or reaching for an item on a shelf. • Another alternative is to have the core dressing item measure a patient's ability to put on a pajama top or a robe. The more general dressing item could then be included in the supplemental items. **Goals:** Predicting payments, outcomes, and discharge placement.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Lower Body Dressing	**G.1.i=Dressing lower body**: dressing and undressing from the waist down, includes prostheses, orthotics, fasteners, pullovers. **0. Independent-resident** completes activity with no help or oversight; **1. Set up assistance**; **2. Supervision-oversight**, encouragement or cueing provided throughout the activity; **3. Limited assistance-guided** maneuvering of limbs or other non-weight bearing assistance provided at least once; **4. Extensive assistance, 1 person assist**-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once; **5. Extensive assistance, 2+person assist**-resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once; **6. Total dependence, 1 person assist**-full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist**-full staff performance of activity (requiring 2 or more person assistance at least once. The resident must be unable or unwilling to perform any part of the activity. **8. Activity did not occur** during entire period.	**39.E Dressing Lower Body** includes dressing and undressing from the waist down, as well as applying and removing a prosthesis or orthosis when applicable. The patient performs the activity safely. No Helper 7 Complete Independence (Timely, Safely); 6 Modified Independence (Device); Helper-Modified Dependence 5 Supervision (Subject=100%); 4 Minimal Assistance (Subject=75% or more); 3 Moderate Assistance (Subject=50% or more); Helper-Complete Dependence 2 Maximal Assistance (Subject = 25% or more); 1 Total Assistance (Subject less than 25%); 0=Activity does not occur; Use this code only at admission	**M0650** – Ability to dress lower body: (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes. 0=Able to obtain, put on, and remove clothing and shoes without assistance; 1=Able to dress lower body without assistance if clothing and shoes are laid out or handed to patient; 2=Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes; 3=Patient depends entirely upon another person to dress lower body; UK=Unknown;	**C0900-Dressing Lower Body**: Performance (what participant actually does) to safely dress lower body including undergarments, slacks, socks or nylons, shoes. 0=Dresses independently-obtains, puts on, and removes clothing and shoes without assistance or supervision, all of the time; 1=Dresses self but uses assistive devices or receives some human assistance-dresses self with assistive devices (e.g., Velcro fasteners on clothing, adaptive clothing and special equipment such as a reacher), dresses lower body without assistance if clothing and shoes are laid out or handed to the participant, does part of dressing but receives assistance for other parts of the activity (e.g., to put on or take off some items of clothing, manage fasteners), dresses or undresses self some of the time and receives assistance at other times; 2=Dresses self but receives constant human assistance-receives stand-by supervision for safety, someone must help the participant put on undergarments, slacks, socks or nylons, and shoes; 3=Completely dependent-patient depends entirely upon another person to dress the lower body all of the time;	**Proposed Item** **A6. Lower Body dressing**: The ability to dress and undress below the waist, including fasteners. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent** - Patient completes the activity by him/her self 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/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 less than half of the time. 2**. Substantial/Maximal Assistance** –Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent** - Helper does ALL of the effort . Person does none of the effort to complete the task. _____ The group does not recommend lower body dressing as a core item. Balance, transfer, and locomotion are recommended as core items and capture similar activities to lower body dressing.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Bed Mobility	**G1.a Bed mobility** moving to and from lying position, turning side to side and positioning body while in bed. **0. Independent-resident** completes activity with no help or oversight; **1. Set up assistance;** **2. Supervision-oversight**, encouragement or cueing provided throughout the activity; **3. Limited assistance**-guided maneuvering of limbs or other non-weight bearing assistance provided at least once; **4. Extensive assistance, 1 person assist**-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once; **5. Extensive assistance, 2+person assist**-resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once; full staff performance of activity (requiring only 1 person **6. Total dependence, 1 person assist**-assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist**-full staff performance of activity (requiring 2 or more person assistance at least once. The resident must be unable or unwilling to perform any part of the activity. **8. Activity did not occur** during entire period.	No equivalent	See Transferring	See Transferring	**Proposed Item** **B1. Lying to Sitting on Side of Bed**: The ability to move from lying on the back to sitting on side of bed with feet flat on the floor, no back support. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent** - Patient completes the activity by him/her self 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/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 less than half of the time. **2. Substantial/Maximal Assistance** –Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent** - Helper does ALL of the effort . Person does none of the effort to complete the task. _____ • The current MDS 3.0 bed mobility item contains several activities and has led to some confusion. Specifying one activity per item may reduce confusion. • If a patient is bed bound, other lower level bed mobility items will be assessed including sit to lying; and turning side to side. • The sitting unassisted for 30 seconds measures endurance more than need for assistance and will be assessed as a Y/N rather than on the 6-level rating scale. • Sitting unassisted is a low-level balance item. This function is basic to toilet and transfer. It differs from other bed mobility items because it measures balance and endurance. _____ **Goals:** Predicting payments, outcomes, and discharge placement.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Sit to Stand	No equivalent item	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **B2. Sit to Stand:** The ability to come to a standing position from sitting in a chair or on the side of a bed. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent** - Patient completes the activity by him/her self 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/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 less than half of the time. **2. Substantial/Maximal Assistance** –Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent** - Helper does ALL of the effort . Person does none of the effort to complete the task.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Chair /Bed to Chair Transfer	**G.1.b-Transfer** moving between surfaces-to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet). 0. Independent-resident completes activity with no help or oversight; 1. Set up assistance; 2. Supervision-oversight, encouragement or cueing provided throughout the activity; 3. Limited assistance-guided maneuvering of limbs or other non-weight bearing assistance provided at least once; 4. Extensive assistance, 1 person assist-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once;	**39I Transfers: Bed, Chair Wheelchair** includes all aspects of transferring from a bed to a chair and back, or from a bed to a wheelchair and back, or coming to a standing position if walking is the typical mode of locomotion. The patient performs the activity safely. Note that Tub and Shower Transfer are separate items. 33.Tub Transfer includes getting into and out of a tub. The patient performs the activity safely. 34 Shower Transfer includes getting into and out of a shower. The patient performs the activity safely.	**M0690-Transferring**: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast. 0-Able to independently transfer. 1-Transfers with minimal assistance or with use of an assistive device. 2-Unable to transfer self but is able to bear weight and pivot during the transfer process. 3-Unable to transfer self and is unable to bear weight or pivot when transferred by another person.	**C0860 Transferring**: Performance (what participant actually does) to safely move from bed to chair, on and off toilet or commode, into and out of tub and shower, and to turn and position self in bed if participant is bedfast. 0-Transfers independently Transfers self to and from bed, chair, toilet, tub/shower without any assistance, all of the time. 1-Transfers, but receives some human assistance or uses assistive device Transfers with minimal human assistance or use of an assistive device, transfers without assistance some of the time and receives assistance at other times, examples a)	**Proposed Item** **B3. Chair/Bed-to-Chair Transfer**: The ability to transfer to and from a chair (or wheelchair). The chairs are placed at right angles to each other. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent** - Patient completes the activity by him/her self 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/Touching Assistance**- Helper provides VERBAL CUES OR TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Chair /Bed to Chair Transfer (continued)	**5. Extensive assistance, 2+person assist-**resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once; **6. Total dependence, 1 person assist**-full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist**-full staff performance of activity (requiring 2 or more person assistance at least once. The resident must be unable or unwilling to perform any part of the activity. 8**. Activity did not occur** during entire period.	No Helper 7 Complete Independence (Timely, Safely); 6 Modified Independence (Device); Helper-Modified Dependence 5 Supervision (Subject=100%); 4 Minimal Assistance (Subject=75% or more); 3 Moderate Assistance (Subject=50% or more); Helper-Complete Dependence 2 Maximal Assistance (Subject = 25% or more); 1 Total Assistance (Subject less than 25%); 0=Activity does not occur; Use this code only at admission	4-Bedfast, unable to transfer but is able to turn and position self in bed. 5-Bedfast, unable to transfer and is unable to turn and position self. UK-Unknown.	Participant transfers independently at home, but requires assistance or supervision when transferring at the Day Health Center, b) Participant transfers independently from bed to chair, but requires assistance to transfer to and from toilet or tub. 2-Does not transfer but bears weight and pivots Participant needs assistance to stand but pivots and sits down without assistance. 3-Does not transfer and does not bear weight or pivot Transferred by another person or persons at all times but is not bedfast. 4-Bedfast, but turns and positions self in bed Unable to transfer, is bedfast but turns and repositions self in bed. 5-Bedfast Unable to transfer, is bedfast, does not turn or reposition self in bed, is transferred by mechanical lift.	**3. Partial/Moderate Assistance-**Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but less than half of the time. 2**. Substantial/Maximal Assistance** –Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent -** Helper does ALL of the effort . Person does none of the effort to complete the task. _____ • This item is modified from the IRF-PAI to exclude standing position from the definition. • This item addresses surface-to-surface transfer only and therefore excludes tub and toilet transfer. **Goals:** Predicting payments, outcomes, and discharge placement.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Toilet Transfer	**G1c. Toilet transfer** how resident gets to and moves on and off toilet or commode. **0. Independent-resident** completes activity with no help or oversight; **1. Set up assistance;** **2. Supervision-oversight**, encouragement or cueing provided throughout the activity; **3. Limited assistance**-guided maneuvering of limbs or other non-weight bearing assistance provided at least once; **4. Extensive assistance, 1 person assist**-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once;	**39J: Toilet transfer** includes safely getting on and off a standard toilet. No Helper 7 Complete Independence (Timely, Safely); 6 Modified Independence (Device); Helper-Modified Dependence 5 Supervision (Subject=100%); 4 Minimal Assistance (Subject=75% or more); 3 Moderate Assistance (Subject=50% or more); Helper-Complete Dependence 2 Maximal Assistance (Subject = 25% or more); 1 Total Assistance (Subject less than 25%);	See transfer.	See transfer.	**Proposed Item** **B4. Toilet Transfer:** The ability to get on and off a toilet or commode. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent** - Patient completes the activity by him/her self 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/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 less than half of the time.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Toilet Transfer (continued)	**5. Extensive assistance, 2+person assist-**resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once; **6. Total dependence, 1 person assist**-full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist**-full staff performance of activity (requiring 2 or more person assistance at least once. The resident must be unable or unwilling to perform any part of the activity. **8. Activity did not occur** during entire period.	0=Activity does not occur; Use this code only at admission	See transfer.	See transfer.	**2. Substantial/Maximal Assistance** –Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent -** Helper does ALL of the effort . Person does none of the effort to complete the task. _____ • Toilet transfer item is more difficult than other surface-to-surface transfers due to constrained space. • This should be a core item because it is highly predictive of a patient's ability to return home. • If the patient is bed bound then they are assessed based on using a bedpan. **Goals:** Predicting payments, outcomes, and discharge placement.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Locomotion/ Ambulation	G1e-**Walk in room** walking between locations in his/her room. G1f-**Walk in facility**-walking in corridor or other places in facility. G1g-L**ocomotion** moving about facility with wheelchair if used. **0. Independent**-resident completes activity with no help or oversight; **1. Set up assistance**; **2. Supervision-oversight**, encouragement or cueing provided throughout the activity; **3. Limited assistance**-guided maneuvering of limbs or other non-weight bearing assistance provided at least once; **4. Extensive assistance, 1 person assist**-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once;	**39L**:Walk includes walking on a level surface once in a standing position. The patient performs the activity safely. **39L**Wheelchair includes using a wheelchair on a level surface once in a seated position. The patient performs the activity safely. **39M** Stairs includes going up and down 12 to 14 stairs (one flight) indoors in a safe manner. 35. **Distanced Walked** (feet) 36. **Distance Traveled in Wheelchair** (feet) No Helper 7 Complete Independence (Timely, Safely); 6 Modified Independence (Device); Helper-Modified Dependence 5 Supervision (Subject=100%); 4 Minimal Assistance (Subject=75% or more); 3 Moderate Assistance (Subject=50% or more);	M0700- **Ambulation/Locomotion:** Ability to SAFELY walk once in a standing position, or use a wheelchair once in a seated position, on variety of surfaces. 0-Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device). 1-Requires us of a device (e.g. cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 2-Able to walk only with the supervision or assistance of another person at all times. 3-Chairfast, unable to ambulate but is able to wheel self independently.	C0850- **Ambulation/Locomotion:** Performance (what participant actually does) to safely walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces. 0-Walks independently Walks on even and uneven surfaces, inside or outside, and climbs stairs (with or without railings) without any human assistance or assistive device. 1-Walks, but receives some human assistance or uses assistive devices Walks alone but requires use of device (e.g., cane, walker), walks without assistance some of the time and receives assistance at other times, examples: a)participant walks independently at home, but requires assistance or supervision when walking at the Day Health center, b) participant needs help negotiating stairs or steps or uneven surfaces.	**Proposed Item** **B5.** Does this patient primarily use a wheelchair for mobility? 0. No 1. Yes **B5a.** Code for the longest distance the patient can walk (observe their performance): 1. Walk 150 ft (45m): Once standing can walk 150 feet (45 meters) in corridor or similar space. 2. Walk 100 ft (30m): Once standing can walk 100 feet (30 meters) in corridor or similar space. 3. Walk 50 ft (15 m): Once standing can walk 50 feet (15 meters) in corridor or similar space 4. Walk in Room Once Standing: Once standing can walk 10 feet (3 meters) in room, corridor or similar space. **B5b.** Code for the longest distance the patient can wheel (observe their performance): 1. Wheel 150 ft (45m):Once sitting can wheel 150 feet (45 meters) in corridor or similar space. 2. Wheel 100 ft (30m): Once standing can wheel 100 feet (30 meters) in corridor or similar space. 3. Wheel 50 ft (15m): Once standing can wheel 50 feet (15 meters in corridor or similar space.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Locomotion/ Ambulation (continued)	**5. Extensive assistance, 2+person assist**-resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once; **6. Total dependence, 1 person assist**-full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist**-full staff performance of activity (requiring 2 or more person assistance at least once. The resident must be unable or unwilling to perform any part of the activity. **8. Activity did not occur** during entire period.	Helper-Complete Dependence 2 Maximal Assistance (Subject = 25% or more); 1 Total Assistance (Subject less than 25%); 0=Activity does not occur; Use this code only at admission	4-Chairfast, unable to ambulate and is unable to wheel self. 5-Bedfast, unable to ambulate or be up in a chair. UK=Unknown	2-Walks, but receives constant assistance Walks only with the supervision or assistance of another person at all times, uses wheelchair some of the time but walks with continuous physical support. 3-Does not walk but uses wheelchair independently Does not walk but does wheel self independently (includes manual wheeling and electronic wheeling); 4-Does not walk but uses wheelchair with assistance Does not walk, confined to a wheelchair and does not wheel self (needs human assistance). 5-Bedfast Does not walk, does not sit up in a chair.	4. Wheel in Room Once Seated: Once seated can wheel 10 feet (3 meters) in room, corridor or similar space. • The items are modified from the MDS 3.0 locomotion items. The modification is that the locomotion items be measured once the patient is in the standing position for walking and once the patient is seated for wheeling. • Patients who walk and use a wheelchair will have responses for all locomotion items. • The walk in room item has been modified to the ability to take ten steps because this is easier to measure uniformly across settings. A step is defined as one heal strike/foot fall. • The second item in both walking and wheelchair is an endurance measure. • Use of a wheelchair is a very different activity than walking and the proposed wheelchair items may include too many activities. This may make it difficult to assess using the rating scale. **Goals:** Predicting payments, outcomes, and discharge placement.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Bathing	G.1.L=Bathing: how resident takes full body bath/shower, sponge bath and transfers in/out of tub/shower excludes washing of back and hair) **0. Independent-resident** completes activity with no help or oversight; **1. Set up assistance**; **2. Supervision-oversight**, encouragement or cueing provided throughout the activity; **3. Limited assistance**-guided maneuvering of limbs or other non-weight bearing assistance provided at least once; **4. Extensive assistance, 1 person assist**-resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once;	39.C=Bathing (note that item 39.K specifies tub and shower transfer) No Helper 7 Complete Independence (Timely, Safely); 6 Modified Independence (Device); Helper-Modified Dependence 5 Supervision (Subject=100%); 4 Minimal Assistance (Subject=75% or more); 3 Moderate Assistance (Subject=50% or more);	M0670 – Bathing: Ability to wash entire body. Excludes grooming (washing hands and face only) 0=Able to bathe in tub or shower independently; 1=With the use of devices, is able to bathe self in shower or tub independently; 2=Able to bathe in shower or tub with the assistance of another person-(a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub OR (c) for washing difficult to reach areas;	C0870-Bathing: Performance (what participant actually does) to safely wash entire body. (Excludes grooming, washing only face and hands), 0=Bathes independently in tub or shower-bathes self in shower or tub independently without any human assistance, supervision, or assistive device, all of the time; 1=Bathes self in shower or tub independently but uses assistive device-with the use of devices (e.g., shower or tub seat, grab bars, hand-held sprayer, long-handled bathing brush), bathes self in shower or tub independently;	**Proposed Item** **C1. Sponge bathe:** The ability to wash, rinse and dry body from neck down (excluding back) while sitting in a char or bed. **C2. Shower/bathe self**: The ability to bathe self in shower or tub, including washing and drying self. Does not include transferring in/out of tub/shower. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent** - Patient completes the activity by him/her self 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.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Bathing (continued)	**5. Extensive assistance, 2+person assist**-resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once; **6. Total dependence, 1 person assist**-full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity. **7. Total dependence, 2+person assist**-full staff performance of activity (requiring 2 or more person assistance at least once. The resident mu. Activity did not occur st be unable or unwilling to perform any part of the activity. 8. Activity did not occur during entire period.	Helper-Complete Dependence 2 Maximal Assistance (Subject = 25% or more); 1 Total Assistance (Subject less than 25%); 0=Activity does not occur; Use this code only at admission	3=Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision; 4=Unable to use the shower or tube and is bathed in bed or bedside chair; 5=Unable to effectively participate in bathing and is totally bathed by another person; UK=Unknown;	2=Bathes self in shower or tub but receives some human assistance/supervision-bathes in shower or tub with the assistance of another person (a)for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub OR (c) for washing difficult to reach areas-bathes independently some of the time and receives assistance at other times (e.g., in the shower at the Day Health Center-sponge bathes self independently (entire body); 3=Bathes self in shower or tub, but receives constant human assistance/supervision-participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision; 4=Must be bathed in bed or bedside chair- does not use shower or tub and is bathed (by sponge bath) in bed or bedside chair, does part of bathing activity (e.g., sponges self in easy to reach areas); 5=Completely dependent-is completely bathed by another person all of the time, receives physical assistance for the entire activity, i.e., does not do any part independently any of the time.	**4. Supervision/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 less than half of the time. **2. Substantial/Maximal Assistance** –Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent** - Helper does ALL of the effort . Person does none of the effort to complete the task. _____ The group does not recommend this as a core item because it may not be valid across settings. Facilities have varying policies on bathing and requirements for supervision. Additionally, the environment contributes significantly to one's ability to bathe independently (i.e., bars, shower chair, stairs in a tub, etc.). Bathing is recommended as a supplemental item. As a supplemental item, the group recommends distinguishing between sponge bathing and regular bathing.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Roll Left or Right/ Sit to Lying	See Bed Mobility	No equivalent item.	See Bed Mobility	See Bed Mobility	**Proposed Item** **C3**. Roll left or right: Ability to roll from lying on back to left or right side and roll back to back. **C4**. Sit to lying: The ability to move from sitting on the side of the bed to lying flat on the bed. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent -** Patient completes the activity by him/her self 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/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 less than half of the time. **2. Substantial/Maximal Assistance –**Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent -** Helper does ALL of the effort . Person does none of the effort to complete the task.
Picking up Object	No equivalent item	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **C5. Picking up object:** Ability to bend/stoop to pick up small object such as a spoon from the floor. **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent -** Patient completes the activity by him/her self 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/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 less than half of the time. **2. Substantial/Maximal Assistance –**Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent -** Helper does ALL of the effort . Person does none of the effort to complete the task.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Mode of Mobility	See Locomotion/Ambulation	See Locomotion/Ambulation	See Locomotion/Ambulation	See Locomotion/Ambulation	**Proposed Item** **C6.** Does this patient primarily use a wheelchair for mobility? 0. No (If no, code C6a-C6d) 1. Yes (If yes, code C6e-C6f) **C6a. 1 step (curb):** The ability to step over a curb or up and down one step. **C6b. Walk 50 feet with two turns:** The ability to walk 50 feet and make two turns **C6c. 12 steps-interior:** The ability to go up and down 12 interior steps. **C6d. Four steps-exterior:** The ability to go up and down 4 exterior steps with or without a rail. **C6e. Wheel short ramp:** Once seated in wheelchair is able to go up and down a ramp of less than 12 feet (4 meters). **C6f. Wheel long ramp:** The ability to go up or down a ramp of more than 12 feet (4 meters) **Rating Scale:** *Activities may be completed with or without assistive devices.* **6. Independent** - Patient completes the activity by him/her self 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/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 less than half of the time. **2. Substantial/Maximal Assistance** –Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs more than half of the time. **1. Dependent** - Helper does ALL of the effort . Person does none of the effort to complete the task.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Telephone	No equivalent item	No equivalent item	**M0770. Ability to Use Telephone:** Ability to answer the phone, dial numbers and effectively use the telephone to communicate. 0. Able to dial numbers and answer calls appropriately and as desired. 1. Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers. 2. Able to answer the telephone and carry on a normal conversation but has difficult with placing calls. 3. Able to answer the telephone only some of the time or is able to carry on only a limited conversation. 4. Unable to answer the telephone at all but can listen if assisted with equipment. 5. Totally unable to use the telephone. NA. Patient does not have a telephone UK. Unknown	**C0970. Telephone Use.** Performance (what participant actually does) to answer the phone, dial numbers, and effectively use the telephone to communicate. 0. Dial numbers and answers calls appropriately and as desired. 1. Uses a specially adapted telephone (e.g., large numbers on the dial, teletype phone for the deaf), effectively places calls and carries on normal conversation. 2. Answers the telephone and carries on normal conversation but has difficultly placing calls. 3. Answers the telephone only some of the time or carries on only a limited conversation. 4. Does not answer the telephone at all but listens if assisted with equipment. 5. Does not use the telephone at all. NA. Participant does not have a telephone.	**Proposed Item** **C7. Telephone-answering:** Ability to pick up call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone. **C8. Telephone-placing call:** Ability to pick up and place call in patient's customary manner and maintain for 3 minutes. Does not include getting to the phone. **Rating Scale:** **4. Independent –**Patient completes the activity by him/herself with no assistance from a helper. **3. Minimal Assistance –** Patient completes the activity with assistance . Helper provides less than half of the effort. **2. Maximum Assistance-**Patient completes the activity with assistance. Helper provides more than half of the effort. **1. Dependent (Total Assistance)-**Helper does none of the effort to complete the task.
Medication Management	—	—	**M0780.** Management of Oral Medications: Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (Note: this refers to ability not compliance or willingness)	**C0490.** Management of Oral Medications: Performance (what the participant actually does) to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable, inhalant/mist, and IV medications. (Assess based on performance during the past week).	**Proposed Item** **C9. 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. **C10. 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.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Medication Management (continued)	—	—	0. Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times 1. Able to take medications at the correct times if (a) individual dosages are prepared in advance by another person or (b) given daily reminders or (c) someone develops a drug diary or chart 2. Unable to take medications unless administered by someone else N/A. No oral medications prescribed UK. Unknown **M0790.** Management of Inhalant/Mist Medications: Patient's ability to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes all other forms of medication (oral tablets, injectable and IV medications). 0. Able to independently take the correct medication and proper dosage at the correct times 1. Able to take medication at the correct times if: (a) individual dosages are prepared in advance by another person, or (b) given daily reminders 2. Unable to take medication unless administered by someone else N/A. No inhalant/mist medications prescribed. UK. Unknown	0. Takes oral medications independently 1. Takes oral medications, but receives some assistance 2. Receives total assistance to take oral medications N/A. No oral medications prescribed **C0500.** Adherence to Medications: Based on your knowledge, observation and/or examination, how closely is the participant's prescribed medication regimen adhered to (e.g., takes appropriate dosage, adheres to medication schedule, etc.)? 0. Poorly 1. Fairly well 2. Completely N/A. Participant does not have prescription medications **C0510.** Adherence to Therapy/Medical Interventions: Based on your knowledge, observation, and/or examination, how closely is the participant's therapy or medical intervention (other than medications) adhered to? (For example, prescribed diet, rehab therapy, etc.) 0. Poorly 1. Fairly well 2. Completely N/A. No therapy or medical intervention	**C11. 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. **Rating Scale:** **4. Independent –**Patient completes the activity by him/herself with no assistance from a helper. **3. Minimal Assistance –** Patient completes the activity with assistance . Helper provides less than half of the effort. **2. Maximum Assistance-**Patient completes the activity with assistance. Helper provides more than half of the effort. **1. Dependent (Total Assistance)-**Helper does none of the effort to complete the task.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Medication Management (continued)	—	—	M0800. Management of Injectable Medications: Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications. Prior/Current 0. Able to independently take the correct medication and proper dosage at the correct times 1. Able to take injectable medication at correct times if: (a) individual syringes are prepared in advance by another person or (b) given daily reminders 2. Unable to take injectable medications unless administered by someone else N/A. No injectable medications prescribed UK. Unknown M0810. Patient Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies): Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. (NOTE: This refers to ability, not compliance or willingness.) 0 Patient manages all tasks related to equipment completely independently 1. If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment 2. Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task 3. Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment 4. Patient is completely dependent on someone else to manage all equipment N/A. No equipment of this type used care	—	—

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Prepare Meal	No equivalent item	No equivalent item	**M0720. Planning and preparing light meals** (e.g., cereal, sandwich) or reheat delivered meals: 0. Able to independently plan and prepare all light meals for self or reheat delivered meals OR is physically, cognitively and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission). 1. Unable to prepare light meals on a regular basis due to physical, cognitive or mental limitations. 2. Unable to prepare any light meals or reheat any delivered meals. UK. Unknown	**C030 Planning and Preparing Light Meals:** Performance (what the participant actually does) to safely and effectively plan and prepare light meals such as cereal, sandwich or reheat delivered meals. 0. Independently plans and prepares all light meals for self or reheats delivered meals OR is physically, cognitively, and mentally able to prepare light meals but does not need or choose to do so. 1. Does not prepare light meals on a regular basis due to physical, cognitive or mental limitation. 2. Does not prepare any light meals or reheat any delivered meals due to physical, cognitive or mental limitations.	**Proposed Item** **C12. Make a light meal:** Ability to plan and prepare all aspects of a light meal such as a bowl of cereal or sandwich and cold drink, or reheat a prepared meal. **Rating Scale:** **4. Independent –**Patient completes the activity by him/herself with no assistance from a helper. **3. Minimal Assistance –** Patient completes the activity with assistance . Helper provides less than half of the effort. **2. Maximum Assistance-**Patient completes the activity with assistance. Helper provides more than half of the effort. **1. Dependent (Total Assistance)-**Helper does none of the effort to complete the task.
Housekeeping	No equivalent item	No equivalent item	**M0750. Housekeeping:** Ability to safely and effectively perform light housekeeping and heavier cleaning tasks. 0. Able to independently perform all housekeeping tasks OR physically, cognitively and mentally able to perform all housekeeping tasks but has not routinely participating in housekeeping tasks in the past (i.e., prior to this home care admission). 1. Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently. 2. Able to perform housekeeping tasks with intermittent assistance or supervision from another person. 3. Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process. 4. Unable to effectively participate in any housekeeping tasks. UK. Unknown	**C0950. Housekeeping:** Performance (what the participant actually does) to safely and effectively perform light housekeeping (e.g., dusting, wiping kitchen counters) and heavier cleaning tasks (e.g., dishwashing, vacuuming, sweeping). 0. Independently perform all housekeeping tasks OR physically, cognitively and mentally able to perform all housekeeping tasks but does not need to do so. 1. Performs only light housekeeping tasks independently. 2. Performs housekeeping tasks with intermittent assistance or supervision from another person 3. Does not consistently perform any housekeeping tasks unless assisted by another person throughout the process 4. Does not effectively participate in any housekeeping tasks unless assisted by another person throughout the process.	**Proposed Item** **C13/ Wipe down surface:** Ability to use a damp cloth to wipe down surface such as a table top or bench to remove small amounts of liquid or crumbs. Includes ability to clean cloth of debris in patient's customary manner. **Rating Scale:** **4. Independent –**Patient completes the activity by him/herself with no assistance from a helper. **3. Minimal Assistance –** Patient completes the activity with assistance . Helper provides less than half of the effort. **2. Maximum Assistance-**Patient completes the activity with assistance. Helper provides more than half of the effort. **1. Dependent (Total Assistance)-**Helper does none of the effort to complete the task.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Shopping	No equivalent item	No equivalent item	**M0760. Shopping:** Ability to plan for, select and purchase items in a store and carry them home or arrange delivery. 0. Able to plan for shopping needs and independently perform shopping tasks, including carrying packages OR physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission). 1. able to go shopping, but needs some assistance: by self is able to do only light shopping and carry small packages but needs someone to do occasional major shopping OR unable to go shopping along but can go with someone to assist. 2. Unable to go shopping alone but is able to identify items needed, place orders and arrange home delivery. 3. Needs someone to do all shopping and errands UK. Unknown	**C0940. Shopping:** Performance (what the participant actually does) to plan for, select and purchase items in a store and carry them home or arrange delivery. 0. Plans for shopping needs and independently performs shopping tasks, including carrying packages OR is physically, cognitively and mentally able to take care of shopping but does not need to do so. 1. Shops but receives assistance: by self does only light shopping and carries small packages but needs someone to do occasional major shopping OR does not go shopping alone, but goes with someone to assist. 2. Does not go shopping, but identifies items needed, places orders, and arranges home delivery. 3. Needs someone to do all shopping due to physical, cognitive or mental limitations.	**Proposed Item** **C14. Light shopping:** Once at store, can locate and select up to five needed goods, take to check out and complete purchasing transaction. **Rating Scale:** **4. Independent –**Patient completes the activity by him/herself with no assistance from a helper. **3. Minimal Assistance –** Patient completes the activity with assistance . Helper provides less than half of the effort. **2. Maximum Assistance-**Patient completes the activity with assistance. Helper provides more than half of the effort. **1. Dependent (Total Assistance)-**Helper does none of the effort to complete the task.
Laundry	No equivalent item	No equivalent item	**M0740. Laundry:** Ability to do own laundry—to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand. 0. Able to independently take care of all laundry tasks OR physically, cognitively and mentally able to do laundry and access facilities but has not routinely performed laundry tasks in the past (i..e., prior to this home care admission).1. Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive or mental limitations, needs. 2. Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation. UK. Unknown	**C0960. Laundry:** Performance (what the participant actually does) to do own laundry such as carry laundry to and from washing machine, use washer and dryer, wash small items by hand. 0. Independently takes care of all laundry tasks OR is physically, cognitively, and mentally able to do laundry and access facilities, but does not need to do so. 1. Does only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry. 2. Does not do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitations.	**Proposed Item** **C15. Laundry:** Includes all aspects of completing a load of laundry using a washer and dryer. Includes sorting, loading and unloading, and adding laundry liquid. **Rating Scale:** **4. Independent –**Patient completes the activity by him/herself with no assistance from a helper. **3. Minimal Assistance –** Patient completes the activity with assistance . Helper provides less than half of the effort. **2. Maximum Assistance-**Patient completes the activity with assistance. Helper provides more than half of the effort. **1. Dependent (Total Assistance)-**Helper does none of the effort to complete the task.

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Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Transportation	No equivalent item	No equivalent item	**M0730. Transportation:** Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway). 0. Able to independently drive a regular or adapted car OR uses a regular handicap-accessible public bus. 1. Able to ride in a car only when driven by another person OR able to use a bus or handicap van only when assisted or accompanied by another person. 2. Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance. UK. Unknown	**C0980. Transportation:** Performance (what the participant actually does) to safely use a car, taxi, or public transportation (bus, train subway) 0. Independently drives a regular or adapted car OR uses a regular or handicap-accessible public bus. 1. Rides in a car only when driven by another person OR uses a bus or handicap van only when assisted or accompanied by another person. 2. Does not ride in a car, taxi, bus or van, and requires transportation by ambulance.	**Proposed Item** **C16. Get in/out of car:** The ability to get into and out of a car or van on the passenger side. Does not include open/close door or fasten seat belt. **C17. Drive a car:** Ability to drive a car in local community **C18. Use public transportation:** Ability to use public transportation. Includes boarding, riding, and alighting from transportation. **Rating Scale:** **4. Independent –**Patient completes the activity by him/herself with no assistance from a helper. **3. Minimal Assistance –** Patient completes the activity with assistance . Helper provides less than half of the effort. **2. Maximum Assistance-**Patient completes the activity with assistance. Helper provides more than half of the effort. **1. Dependent (Total Assistance)-**Helper does none of the effort to complete the task.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
VII. Engagement	—	—	—	—	—
Engagement	**E6. Rejection of Care-Presence.** In the last 5 days, did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals. 0. No 1. Yes **E7. Rejection of Care—Frequency.** Number of days on which care was rejected. 1. 1-2 days 2. 3 or more days	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **A1.** Indicate the patient's cognitive and emotional resources to comprehend current services, tolerate typical frustrations of care and participate actively in the treatments. 6. No problem: Participates willingly in treatment; appreciates value of care; places frustrations in perspective 5. Minimal problem: Participates in treatments; infrequently questions value of activities; infrequent difficulty with frustrations 4. Mild problem: Requires occasional encouragement; occasionally questions value of activities/occasional difficulty with frustrations 3. Moderate problem: Requires frequent encouragement; frequently questions value of activities/difficulty dealing with frustrations; much time spent explaining goals/rationale rather than executing treatment plan. 2. Moderate to severe problem: Requires consistent encouragement; does not value treatment; continuous difficulty in dealing with frustrations. 1. Severe problem: Refuses to participate, requests discharge. 8. Not assessed

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
VIII. Frailty/Life Expectancy	—	—	—	—	—
Frailty/Life Expectancy	**J14. Prognosis.** Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? Requires physician documentation. If not documented, discuss with physician and request supporting documentation) 0. No 1. Yes	No equivalent item	**M0260. Overall Prognosis**. BEST description of patient's overall prognosis for recovery from this episode of illness. 0. Poor: little or no recovery is expected and/or further decline is imminent 1. Good/Fair: partial to full recovery is expected UK. Unknown **M0270. Rehabilitative Prognosis.** BEST description of patient's prognosis for functional status. 0. Guarded: minimal improvement in functional status is expected; decline is possible 1. Good: marked improvement in functional status is expected. UK. Unknown **M0280. Life Expectancy**. Physician documentation is not required. 0. Life expectancy is greater than 6 months 1. Life expectancy is 6 months or fewer	**C0250. Overall Prognosis.** BEST description of participant's overall prognosis. 0. Poor: imminent decline likely 1. Fair: maintenance likely 2. Good: some improvement expected **C0260. Life Expectancy**. Would it be unexpected if the participant died in the next six months? 0. No 1. Yes **C0520. Self-Report of Health Status.** Compared to other people your age, would you say that your health is excellent, good, fair or poor? 1. Excellent 2. Good 3. Fair 4. Poor UA. Participant was asked this question and was unable to answer due to cognitive impairment.	**Proposed Item** **A1.** Would you be surprised if the patient was readmitted to an acute care hospital in the next 6 months? 0. No 1. Yes 8. Not assessed 9. Unknown **A2.** Would you be surprised if the patient were to die in the next 12 months? 0. No 1. Yes 8. Not assessed 9. Unknown • This item would be important for measuring outcomes and understanding resource utilization and CARE placement. • The item provides understanding of the patient's potential for recovery versus likelihood of death. • The group reviewed both self-report items and clinician reported items for life expectancy/prognosis. The group recommends the use of a clinician report item but is open to the discussion of including an item capturing self-report of health status. • One issue is that clinician's may not feel qualified to make determinations regarding likelihood of death Clinician's may also feel uneasy about asking individuals to assess their own health status. • The group reviewed items from the legacy instruments as well as the National Health Interview Survey, the National Long Term Care Survey, the Health and Retirement Survey, the Medicare Current Beneficiary Survey and the British Gold Standards.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
IX. Discharge Status	—	—	—	—	—
Discharge Date	No equivalent item	**40.** Discharge Date	**M0906. Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer or death (at home) of the patient	No equivalent item.	**Proposed Item** **A1. Discharge Date**
Discharge Location	No equivalent item	**44A.** Discharge to Living Setting 1. Home 2. Board and Care 3. Transitional Living 4. Intermediate Care 5. Skilled Nursing Facility 6. Acute Unit of Own Facility 7. Acute Unit of Another Facility 8. Chronic Hospital 9. Rehabilitation Facility 10. Other 12. Alternate Level of Care Unit 13. Subacute Setting 14. Assisted Living Residence	**M0855.** To which Inpatient Facility has the patient been admitted? 1. Hospital 2. Rehabilitation facility 3. Nursing home 4. Hospice 5. No Inpatient Facility **M0870.** Discharge Disposition: Where is the patient after discharge from your agency? 1. Patient remains in the community (not in hospital, nursing home, or rehab facility) 2. Patient transferred to a noninstitutional hospice 3. Unknown because patient moved to geographic location not served by this agency 4. Other unknown	No equivalent item	**Proposed Item:** **Discharge Location.** Where will the patient be discharged to? 1. Private residence 2. Other community-based residence setting (e.g., assisted living residents, group home, adult foster care) 3. Long-term care facility/nursing home 4. Skilled nursing facility (includes subacute) (SNF/TCU) 5. Short-stay acute hospital (IPPS) 6. Long-term care hospital (LTCH) 7. Inpatient rehabilitation hospital or unit (IRF) 8. Psychiatric hospital or unit 9. Inpatient hospice care 10. Other (e.g., shelter, jail, no known address) 11. Discharged against medical advice. • This item is important for measuring outcomes but not for setting payments or predicting settings. • Similar items in other instruments were thought to have too many categories, some of which may be state specific and others that did not seem distinct. The recommended re-categorization comes from the social/environmental group participants, other suggestions are welcome. • Home is often the default response for this item. • The item captures some settings that are not usually seen in claims like assisted living, home, home alone.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Frequency of Assistance	No equivalent item	No equivalent item	**M0370**. How often does patient receive assistance from the primary caregiver? 1. Several times during day and night 2. Several times during day 3. Once daily 4. Three or more times per week 5. One to two times per week 6. Less often than weekly 7. Unknown	**C0620.** Frequency of informal care assistance. How frequently does the participant receive assistance from informal caregiver(s)? 0. Less often than weekly 1. One to two times per week 2. Three or more times per week 3. Once daily 4. Several times during the day or night 5. Several times during the day and night	**Proposed Item** **A3.** How often will the patient require assistance (physical or supervision) from a caregiver(s) or provider(s)? 1. Patient does not require assistance 2. Weekly or less (e.g., requires help with grocer shopping or errands, etc.) 3. Less than daily but more often than weekly 4. Intermittently during the day or night 5. All night but not during the day 6. All day but not at night 7. 24 hours per day • This item is not important for setting payments but is important to case-mix adjust for outcomes. It is also a strong predictor of settings. • The item does not need to be completed for those in a long term care facility. • The group adapted the response categories. "Several times" was thought to be a little too vague. Weekly assistance is closely tied to IADL assistance, which is being captured separately in the function section.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Lives with After Discharge	No equivalent item	**45**. Discharge to Living With. 1. Alone 2. Family/relatives 3. Friends 4. Attendant 5. Other	No equivalent item	No equivalent item	**Proposed Item:** **Patient Lives With at Discharge.** Upon discharge, who will the patient live with? 1. Will Live Alone 2. Spouse or Significant Other 3. Adult Child (≥18 years old) 4. Other Child (≤ 18 years old) 5. Other unpaid family member or friend 6. Paid help living the home 7. Unknown • The item is not important for setting payments but is useful for measuring outcomes and predicting settings (particularly if there is no one to live with). • This item can feed into discussions about whether a patient should/can go home or to an IRF or SNF. • Changes in living setting pre and post discharge are a useful outcomes measure to understand. • The person a patient lives with is an important indicator of support and assesses the extent of informal care available in the home. • The item does not quantify the hours of support that someone may have or their willingness or ability to provide care. • The strongest predictor of outcomes from the OASIS is whether someone has paid help in the home.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Caregiver Availability	No equivalent item	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **B2. Caregiver(s) Availability at Discharge.** Does the patient currently have one or more caregiver(s) both willing and able to provide the necessary care? 0. No 1. Yes • This item is not important for setting payments or measuring outcomes. However, it is useful for understanding placement. • This item does not need to be completed for those residing in a long term care facility or if the patient is independent and able to provide self-care. • A distinction between primary/secondary caregiver(s) is not important. It is more important to understand what an individual can do independently (function) and whether assistance is available for limited function. • The most important measure is if there is an informal caregiver who can provide ADL assistance. • "Willing and able" is a concept that is difficult to define and capture. Is there any alternative terminology or definition that could be used for clarification?

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Types of Caregivers	No equivalent item	No equivalent item	**M0350.** Assisting person(s) other than home care agency staff 1. Relatives 2. Friends or neighbors living outside the home 3. Person residing in the home (excluding paid help) 4. Paid help; 5. none of the above 6. Unknown **M0360.** Primary caregiver taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff): 1. No one person 2. Spouse or significant other 3. Daughter or son 4. Other family member 5. Friend or neighbor or community or church member 6. Paid help 7. Unknown	**C06000.** Informal (Unpaid) Caregiver(s) who regularly (at least once a month) provide assistance to the participant. Mark all that apply 1. No informal caregiver 2. Friends, or neighbors living outside the home 3. Person residing in the home (excluding paid help)	**Proposed Item** **B3. Types of Caregiver(s).** What is the relationship of the caregiver(s) to the patient? 1. Spouse or significant other 2. Child 3. Other unpaid family member or friend 4. Paid help • The informal caregiver can be in health care but should not be in home care. A private duty nurse is other paid help. • This item may be difficult for clinicians to adequately report. It is important to request this information of the patients. • Additional caregiver items, such as the Zarit items were proposed for use in the CARE tool. The Zarit items, in particular, are most applicable if informal caregiving as been ongoing for a while. • Primary caregiver and all types of assistance should be combined into a single item. Primary versus secondary caregiver does not matter. What does matter is ADL or IADL, i.e., the type of assistance required. • The weakness of this item is that it does not capture what is actually going to happen in terms of caregiving once the patient is discharged. • Another weakness of this item is that the nursing disciplines may not have enough information to accurately answer these questions.

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Types of Caregivers (continued)	—	—	—	—	• This item does not work well in predicting outcomes because it is not well filled out. Ex. For home health nurses, sometimes they enter homes for brief visits and they do not observe who is in the home. They often do not probe as much as they should to determine whether there is a caregiver in the home and who it is. • Some evidence of too much informal care (Joan Penrod's research) • Even without cognitive or functional deficits a patient may need medical assistance. For example, a patient may have a wound dressing that needs to be changed daily, that they could not physically reach on their own.
Financial Means for Medications	No equivalent item	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **C1.** Will the patient be able to pay for their medications after discharge? 0. No 1. Yes 8. Unable to assess (e.g., patient unresponsive, communication disorder, no interpreter available, other) 9. Unknown to patient
Medication Management	No equivalent item	No equivalent item	See Medication Management	See Medication Management	**Proposed Item** **C2.** Will the patient be able to manage their medications after discharge? 1. Yes, able to manage medications independently 2. Yes, able to manage medications with assistance 3. No, unable to manage medications 4. Not applicable, no medications 9. Unknown

(continued)

Table A-1 (continued)
Comparison of items across legacy instruments and justifications for inclusion

Item	SNF (draft MDS 3.0)	IRF-PAI (revised)	OASIS	COCOA-B	CARE TOOL
Transportation Options	No equivalent item	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **C3.** How will the patient be transported to any follow up physician appointments and/or outpatient therapies or treatments? 1. No follow-up physician appointments and/or outpatient therapies or treatments planned 2. Can drive self 3. Family member or friend will drive patient 4. Public transportation 5. Other (specify) 8. Unable to assess (e.g., patient unresponsive, communication disorder, no interpreter available, other) 9. Unknown to patient
Discharge Care Options	No equivalent item	No equivalent item	No equivalent item	No equivalent item	**Proposed Item** **D.** Please indicate whether the following services were considered appropriate for the patient at discharge (check all that apply). Services: Home Health Care (HHA) Skilled Nursing Facility (SNF) Inpatient Rehabilitation Hospital (IRF) Long-term Care Hospital (LTCH) Psychiatric Hospital Outpatient Services Acute Hospital Admission Hospice Rating Options Deemed appropriate by the provider Bed/services available Refused by patient/family Not covered by insurance

SOURCE: RTI International.

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APPENDIX B:
CARE TOOL MASTER DOCUMENT
(CORE AND SUPPLEMENTAL ITEMS):
POST-OMB VERSION, 10/29/07

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CARE Tool

Master Document
(Core and Supplemental Items)

General Information: Please note that this instrument uses the term "2-day assessment period" to refer to the first 2 days of admission and the last 2 days prior-to-discharge for look-back periods.

Post OMB Version
10/29/07

Signatures of Persons 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)	III A2-6	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

I. Administrative Items

A. Assessment Type

A1. Reason for assessment (Enter Code)

1. Acute discharge
2. PAC admission
3. PAC discharge
4. Interim
5. Expired

A2. Admission Date _____/_____/_____ (MM DD YYYY)

A3. Assessment Reference Date _____/_____/_____ (MM DD YYYY)

A4. Expired Date (leave blank if not applicable)

_____/_____/_____ (MM DD YYYY)

B. Provider Information

B1. Provider's Name

B2. Medicare Provider's Identification Number

B3. National Provider Identification Code (NPI)

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

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

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

C7. Patient's Identification/Provider Account Number

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

C8. Birth Date

_____/_____/_____ (MM DD YYYY)

C9. Social Security Number (optional)

|___|___|___|-|___|___|-|___|___|___|___|

C10. Gender (Enter Code)

1. Male
2. Female

C11. Race/Ethnicity (Check all that apply)

- a. American Indian or Alaska Native
- b. Asian
- c. Black or African American
- d. Hispanic or Latino
- e. Native Hawaiian or Pacific Islander
- f. White
- g. Unknown

C12. Is English the patient's primary language? (Enter Code)

0. No
1. Yes *(If Yes, skip to C13.)*

C12a. If English is not the patient's primary language, what is the patient's primary language?

_____

C13. Does the patient want or need an interpreter (oral or sign language) to communicate with a doctor or health care staff? (Enter Code)

0. No
1. Yes

I. Administrative Items (cont.)

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 this section? _____ *(minutes)*

II. Admission Information

A. Pre-admission Service Use

A1. Admission Date

_____/_____/_____
MM DD YYYY

A3. If admitted from a medical setting, what was the primary diagnosis being treated in the previous setting?

_____

Enter Code ☐

A2. Admitted From. Immediately preceding this admission, where was the patient?

1. **Directly from community** (e.g., private home, assisted living, group home, adult foster care)
2. **Long-term nursing facility**
3. **Skilled Nursing Facility (SNF/TCU)**
4. **Hospital emergency department**
5. **Short-stay acute hospital**
6. **Long-term care hospital** (LTCH)
7. **Inpatient rehabilitation hospital or unit** (IRF)
8. **Psychiatric hospital or unit**
9. **Other** (specify)_____

Check all that apply

A4. In the last 2 months, what medical services other than those identified in A2 has the patient received?

- ☐ a. **Skilled Nursing Facility (SNF/TCU)**
- ☐ b. **Short-stay acute hospital** (IPPS)
- ☐ c. **Long-term care hospital** (LTCH)
- ☐ d. **Inpatient rehabilitation hospital or unit** (IRF)
- ☐ e. **Psychiatric hospital or unit**
- ☐ f. **Home health**
- ☐ g. **Hospice**
- ☐ h. **Outpatient**
- ☐ i. **None**

B. Patient History Prior To This Current Illness, Exacerbation, or Injury

B1. Prior to this recent illness, where did the patient live?

Enter Code ☐

1. **Private residence**
2. **Community based residence** (e.g., assisted living residence, group home, adult foster care)
3. **Permanently in a long-term care facility** (e.g., nursing home)
4. **Other** (e.g., shelter, jail, no known address)
9. **Unknown**

B2. If the patient lived in the community prior to this illness, please provide the patient's ZIP Code (if patient's residence was in U.S.).

|___|___|___|___|___|

☐ **Lives Outside U.S.** ☐ **Unknown**

Check all that apply

B3. If the patient lived in the community prior to this illness, what help was used?

- ☐ a. **No help received or no help necessary**
- ☐ b. **Unpaid Assistance**
- ☐ c. **Paid Assistance**
- ☐ d. **Unknown**

B3a. If the patient lived in the community prior to this illness, who did the patient live with? (Check all that apply.)

- ☐ a. **Lives alone**
- ☐ b. **Lives with paid helper**
- ☐ c. **Lives with other(s)**
- ☐ d. **Unknown**

II. Admission Information (cont.)

B4. If the patient lived in the community prior to this current illness, exacerbation, or injury, are there any structural barriers in the patient's **prior residence** that could interfere with the patient's discharge?

Check all that apply

- ☐ **a.** Structural barriers are **not an issue**.
- ☐ **b.** **Stairs inside the living setting** that must be used by patient (e.g., to get to toileting, sleeping, eating areas).
- ☐ **c.** **Stairs leading from inside to outside** of living setting.
- ☐ **d.** **Narrow or obstructed doorways** for patients using wheelchairs or walkers.
- ☐ **e.** **Insufficient space** to accommodate **extra equipment** (e.g., hospital bed, vent equipment).
- ☐ **f.** **Other** (specify) _____.
- ☐ **g.** **Unknown**

B5. Prior Functioning. Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury.

3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.

2. Needed partial assistance – Patient needed partial assistance from another person to complete activities.

1. Dependent – A helper completed the activity for the patient.

8. Not Applicable

9. Unknown

Enter ☐ Code	**B5a. Self Care:** Did the patient need help bathing, dressing, using the toilet, or eating?
Enter ☐ Code	**B5b. Mobility (Ambulation):** Did the patient need assistance with walking from room to room (with or without devices such as cane, crutch, or walker)?
Enter ☐ Code	**B5c. Stairs (Ambulation):** Did the patient need assistance with stairs (with or without devices such as cane, crutch, or walker)?
Enter ☐ Code	**B5d. Mobility (Wheelchair):** Did the patient need assistance with moving from room to room using a wheelchair, scooter, or other wheeled mobility device?
Enter ☐ Code	**B5e. Functional Cognition:** Did the patient need help planning regular tasks, such as shopping or remembering to take medication?

B6. Mobility Devices and Aids Used Prior to Current Illness, Exacerbation, or Injury (Check all that apply.)

Check all that apply

- ☐ **a.** **Cane/crutch**
- ☐ **b.** **Walker**
- ☐ **c.** **Orthotics/Prosthetics**
- ☐ **d.** **Wheelchair/scooter full time**
- ☐ **e.** **Wheelchair/scooter part time**
- ☐ **f.** **Mechanical lift required**
- ☐ **g.** **Other** (specify) _____
- ☐ **h.** **None apply**
- ☐ **i.** **Unknown**

Enter ☐ Code

B7. History of Falls. Has the patient had two or more falls in the past year or any fall with injury in the past year?

0. No

1. Yes

9. Unknown

T.II How long did it take you to complete this section? _____ *(minutes)*

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. For discharge only, these lists can be added to throughout the stay and will be specific to each setting.

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

B1.	
B2.	
B3.	
B4.	
B5.	
B6.	
B7.	
B8.	
B9.	
B10.	
B11.	
B12.	
B13.	
B14.	

Enter ☐ Code

B15. Is this list complete?
0. No
1. Yes

III. Current Medical Information (cont.)

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

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. 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? (Please note: "Used at any time during stay" is only necessary at discharge.)

Check all that apply

Admitted/Discharged With:	Used at Any Time During Stay		
D1a. ☐	D1b. ☐	D1.	**None**
D2a. ☐	D2b. ☐	D2.	**Insulin Drip**
D3a. ☐	D3b. ☐	D3.	**Total Parenteral Nutrition**
D4a. ☐	D4b. ☐	D4.	**Central Line Management**
D5a. ☐	D5b. ☐	D5.	**Blood Transfusion(s)**
D6a. ☐	D6b. ☐	D6.	**Controlled Parenteral Analgesia – Peripheral**
D7a. ☐	D7b. ☐	D7.	**Controlled Parenteral Analgesia – Epidural**
D8a. ☐	D8b. ☐	D8.	**Left Ventricular Assistive Device** (LVAD)
D9a. ☐	D9b. ☐	D9.	**Continuous Cardiac Monitoring** ***D9c.*** *Specify reason for continuous monitoring:* _____
D10a. ☐	D10b. ☐	D10.	**Chest Tube(s)**
D11a. ☐	D11b. ☐	D11.	**Trach Tube with Suctioning** ***D11c.*** *Specify most intensive frequency of suctioning during stay:* *Every_____ hours*
D12a. ☐	D12b. ☐	D12.	**High O_2 Concentration Delivery System** with FiO_2 > 40%
D13a. ☐	D13b. ☐	D13.	**Non-invasive ventilation**
D14a. ☐	D14b. ☐	D14.	**Ventilator – Weaning**
D15a. ☐	D15b. ☐	D15.	**Ventilator – Non-Weaning**
D16a. ☐	D16b. ☐	D16.	**Hemodialysis**
D17a. ☐	D17b. ☐	D17.	**Peritoneal Dialysis**
D18a. ☐	D18b. ☐	D18.	**Fistula or Other Drain Management**
D19a. ☐	D19b. ☐	D19.	**Negative Pressure Wound Therapy**
D20a. ☐	D20b. ☐	D20.	**Complex Wound Management** with positioning and skin separation/traction that requires at least two persons
D21a. ☐	D21b. ☐	D21.	**Halo**
D22a. ☐	D22b. ☐	D22.	**Complex External Fixators** (e.g., Ilizarov)
D23a. ☐	D23b. ☐	D23.	**One-on-One 24-Hour Supervision** ***D23c.*** *Specify reason for 24-hour supervision:* _____
D24a. ☐	D24b. ☐	D24.	**Specialty Surface or Bed** (i.e., air fluidized, bariatric, low air loss, or rotation bed)
D25a. ☐	D25b. ☐	D25.	**Multiple IV Antibiotic Administration**
D26a. ☐	D26b. ☐	D26.	**IV Vaso-actors** (e.g., pressors, dilators, medication for pulmonary edema)
D27a. ☐	D27b. ☐	D27.	**IV Anti-coagulants**
D28a. ☐	D28b. ☐	D28.	**IV Chemotherapy**
D29a. ☐	D29b. ☐	D29.	**Indwelling Bowel Catheter Management System**
D30a. ☐	D30b. ☐	D30.	**Other Major Treatments** ***D30c.*** *Specify*_____

III. Current Medical Information (cont.)

E. Medications

List all current medications for the patient during the 2-day assessment period. These can be exported to an electronic file for merging with the assessment data.

	Medication Name	Dose	Route	Frequency	Planned Stop Date (if applicable)
E1	E1a.	E1b.	E1c.	E1d.	E1e. ___/___/___
E2	E2a.	E2b.	E2c.	E2d.	E2e. ___/___/___
E3	E3a.	E3b.	E3c.	E3d.	E3e. ___/___/___
E4	E4a.	E4b.	E4c.	E4d.	E4e. ___/___/___
E5	E5a.	E5b.	E5c.	E5d.	E5e. ___/___/___
E6	E6a.	E6b.	E6c.	E6d.	E6e. ___/___/___
E7	E7a.	E7b.	E7c.	E7d.	E7e. ___/___/___
E8	E8a.	E8b.	E8c.	E8d.	E8e. ___/___/___
E9	E9a.	E9b.	E9c.	E9d.	E9e. ___/___/___
E10	E10a.	E10b.	E10c.	E10d.	E10e. ___/___/___
E11	E11a.	E11b.	E11c.	E11d.	E11e. ___/___/___
E12	E12a.	E12b.	E12c.	E12d.	E12e. ___/___/___
E13	E13a.	E13b.	E13c.	E13d.	E13e. ___/___/___
E14	E14a.	E14b.	E14c.	E14d.	E14e. ___/___/___
E15	E15a.	E15b.	E15c.	E15d.	E15e. ___/___/___
E16	E16a.	E16b.	E16c.	E16d.	E16e. ___/___/___
E17	E17a.	E17b.	E17c.	E17d.	E17e. ___/___/___
E18	E18a.	E18b.	E18c.	E18d.	E18e. ___/___/___
E19	E19a.	E19b.	E19c.	E19d.	E19e. ___/___/___
E20	E20a.	E20b.	E20c.	E20d.	E20e. ___/___/___
E21	E21a.	E21b.	E21c.	E21d.	E21e. ___/___/___
E22	E22a.	E22b.	E22c.	E22d.	E22e. ___/___/___
E23	E23a.	E23b.	E23c.	E23d.	E23e. ___/___/___
E24	E24a.	E24b.	E24c.	E24d.	E24e. ___/___/___
E25	E25a.	E25b.	E25c.	E25d.	E25e. ___/___/___
E26	E26a.	E26b.	E26c.	E26d.	E26e. ___/___/___
E27	E27a.	E27b.	E27c.	E27d.	E27e. ___/___/___
E28	E28a.	E28b.	E28c.	E28d.	E28e. ___/___/___
E29	E29a.	E29b.	E29c.	E29d.	E29e. ___/___/___
E30	E30a.	E30b.	E30c.	E30d.	E30e. ___/___/___

Enter Code

E31. Is this list complete?

0. No

1. Yes

III. Current Medical Information (cont.)

F. Allergies & Adverse Drug Reactions

Enter Code

F1. Does patient **have allergies or any known adverse drug reactions?**
0. None known *(If **Unknown**, skip to Section G. Skin Integrity.)*
1. Yes *(If **Yes**, list all allergies/causes of reaction [e.g., food, medications, other] and describe the adverse reactions.)*

Allergies/Causes of Reaction	Patient Reaction
F1a. _____	F1b. _____
F2a. _____	F2b. _____
F3a. _____	F3b. _____
F4a. _____	F4b _____
F5a. _____	F5b. _____
F6a. _____	F6b. _____
F7a. _____	F7b. _____
F8a. _____	F8b. _____

Enter Code

F9. Is the list complete?
0. No
1. Yes

G. Skin Integrity

G1-2. PRESENCE OF PRESSURE ULCERS

Enter Code

G1. Is this patient at **risk of developing pressure ulcers**?
0. No
1. Yes, indicated by clinical judgment
2. 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.**

Enter Code

G2. Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher?
0. No *(If **No**, skip to Section 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:

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

Number present at assessment	Number with onset during this service	Pressure ulcer at stage 2, stage 3, or stage 4 only:
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 (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."

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 Section G6. Turning Surfaces Not Intact.)*
1. **Yes**

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

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

Date Measured

__ _/_ __/ ____

MM DD YYYY

G3. If any pressure ulcer is stage 3 or 4 (or if eschar is present) during the 2-day assessment period, please record the most recent measurements for the LARGEST ulcer (or eschar):

a. **Longest length in any direction**

b. **Width of SAME unhealed ulcer or eschar**

c. **Date of measurement**

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. _____

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**

G6. TURNING SURFACES NOT INTACT

Indicate which of the following turning surfaces have either a pressure ulcer or major wound.

Check All That Apply

Turning Surface	
☐	**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

Record the most recent value for each of the following physiologic factors. 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 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/mm³)
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 (%)
				Arterial Blood Gases (ABGs)
H23a. / /			H23c. ☐	*H23d. Please specify source and amount of supplemental O2* _____
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.	xxxx	H31b.	H31c. ☐	H31. FVC (cc's)
H32.	xxx	H32b.	H32c. ☐	H32. FEV (% of FVC)
H33.	xxx	H33b.	H33c. ☐	H33. FEV1 (% of FVC in 1 second)
H34.	xxx	H34b.	H34c. ☐	H34. FEV2 (% of FVC in 2 seconds)
H35.	xxx	H35b.	H35c. ☐	H35. FEV3 (% of FVC in 3 seconds)
H36.	xxx	H36b.	H36c. ☐	H36. PEF (liters per minute)
H37.	xx,x	H37b.	H37c. ☐	H37. MVV (liters per minute)
H38.	xxxx	H38b.	H38c. ☐	H38. SVC (cc's)
H39.	xxxx	H39b.	H39c. ☐	H39. TLC (cc's)
H40.	xxxx	H40b.	H40c. ☐	H40. FRC (cc's)
H41.	xxxx	H41b.	H41c. ☐	H41. RV (cc's)
H42.	xxxx	H42b.	H42c. ☐	H42. ERV (cc's)

T.III How long did it take you to complete this section? _____ *(minutes)*

IV. Cognitive Status, Mood and Pain

A. Comatose

Enter Code

A1. Persistent vegetative state/no discernible consciousness at time of admission (discharge)
- **0. No**
- **1. Yes** *(If Yes, skip to G6. Pain Observational Assessment.)*

B. Temporal Orientation/Mental Status

B1. Interview Completed

Enter Code

B1a. Interview Attempted?
- **0. No**
- **1. Yes** *(If Yes, skip to B2a. [for acute care discharges] or B3. BIMS (for PAC admissions.)*

Enter Code

B1b. Indicate reason that the interview was not attempted and *then skip to Section C. Observational Assessment of Cognitive Status*:
- **1. Unresponsive or minimally conscious**
- **2. Communication disorder**
- **3. No interpreter available**

B2. Temporal Orientation Complete only for acute care discharges.

Enter Code

B2a. Ask patient: *"Please tell me what year it is right now."*
Patient's answer is:
- **3. Correct**
- **2. Missed by 1 year**
- **1. Missed by 2 to 5 years**
- **0. Missed by more than 5 years or no answer**

Enter Code

B2b. Ask patient: *"What month are we in right now?*
Patient's answer is:
- **2. Accurate within 5 days**
- **1. Missed by 6 days to 1 month**
- **0. Missed by more than 1 month or no answer**

B3. BIMS Complete only for PAC admission.

Enter Code

B3a. Repetition of Three Words
Ask patient: *"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."*
Number of words repeated by patient after first attempt:
- **3. Three**
- **2. Two**
- **1. One**
- **0. None**

After the patient's first attempt say: *"I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture."* **You may repeat the words up to two more times.**

Enter Code

B3b. Year, Month, Day
B3b.1. Ask patient: *"Please tell me what year it is right now."*
Patient's answer is:
- **3. Correct**
- **2. Missed by 1 year**
- **1. Missed by 2 to 5 years**
- **0. Missed by more than 5 years or no answer**

Enter Code

B3b.2. Ask patient: *"What month are we in right now?*
Patient's answer is:
- **2. Accurate within 5 days**
- **1. Missed by 6 days to 1 month**
- **0. Missed by more than 1 month or no answer**

Enter Code

B3b.3. Ask patient: *"What day of the week is today?"*
Patient's answer is:
- **2. Accurate**
- **1. Incorrect or no answer**

B3c. Recall
Ask patient: *"Let's go back to the first question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word.

Enter Code

B3c.1. Recalls "sock?"
- **2. Yes**, no cue required
- **1. Yes**, after cueing ("something to wear")
- **0. No**, could not recall

Enter Code

B3c.2. Recalls "blue?"
- **2. Yes**, no cue required
- **1. Yes**, after cueing ("a color")
- **0. No**, could not recall

Enter Code

B3c.3. Recalls "bed?"
- **2. Yes**, no cue required
- **1. Yes**, after cueing ("a piece of furniture")
- **0. No**, could not recall

IV. Cognitive Status, Mood & Pain (cont.)

C. Observational Assessment of Cognitive Status at 2-Day Assessment Period: Complete this section only if patient could not be interviewed.

Check all that apply

C1. Memory/recall ability: Check all that the patient normally recalled during the 2-day assessment period:

- ☐ **C1a. Current season**
- ☐ **C1b. Location of own room**
- ☐ **C1c. Staff names and faces**
- ☐ **C1d. That he or she is in a hospital, nursing home, or home**
- ☐ **C1e. None of the above are recalled**
- ☐ **C1f. Unable to assess**

  Specify reason _____

D. Confusion Assessment Method: Complete this section only if patient scored 0 or 1 on B2a. or B2b. (for acute care discharges) or B3b.1., B3b.2., or B3b.3 (for PAC admissions).

Code the following behaviors during the 2-day assessment period.

CODING:

0. Behavior **is not present.**
1. Behavior **continuously present** does not fluctuate.
2. Behavior **present, fluctuates** (e.g., comes and goes, changes in severity).

Enter Code in Boxes →

Enter ☐ Code	**D1. Inattention:** The patient has difficulty focusing attention (e.g., easily distracted, out of touch, or difficulty keeping track of what is said).
Enter ☐ Code	**D2. Disorganized thinking:** The patient's thinking is disorganized or incoherent (e.g., rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching of topics or ideas).
Enter ☐ Code	**D3. Altered level of consciousness/alertness:** The patient has an altered level of consciousness: vigilant (e.g., startles easily to any sound or touch), lethargic (e.g., repeatedly dozes off when asked questions, but responds to voice or touch), stuporous (e.g., very difficult to arouse and keep aroused for the interview), or comatose (e.g., cannot be aroused).
Enter ☐ Code	**D4. Psychomotor retardation:** Patient has an unusually decreased level of activity (e.g., sluggishness, staring into space, staying in one position, moving very slowly).

IV. Cognitive Status, Mood & Pain (cont.)

E. Behavioral Signs & Symptoms: PAC Admission and Discharge

Has the patient exhibited any of the following behaviors during the 2-day assessment period?

Enter Code

E1. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing).
- **0. No**
- **1. Yes**

Enter Code

E2. Verbal behavioral symptoms directed towards others (e.g., threatening, screaming at others).
- **0. No**
- **1. Yes**

Enter Code

E3. Other disruptive or dangerous behavioral symptoms not directed towards others, including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs, pacing).
- **0. No**
- **1. Yes**

F. Mood: PAC Admission and Discharge

Enter Code

F1. Mood Interview Attempted?
- **0. No** *(If **No**, skip to Section G1. Pain Interview.)*
- **1. Yes**

F2. Patient Health Questionnaire (PHQ2): PAC Admission and Discharge

Ask patient: *"During the last 2 weeks, have you been bothered by any of the following problems?"*

Enter Code

F2a. Little interest or pleasure in doing things?
- **0. No** *(If **No**, skip to question F2c.)*
- **1. Yes**
- **8. Unable to respond** *(If **Unable**, skip to question F2c.)*

Enter Code

F2b. If **Yes**, how many days in the last 2 weeks?
- **0. Not at all (0 to 1 days)**
- **1. Several days (2 to 6 days)**
- **2. More than half of the days (7 to 11 days)**
- **3. Nearly every day (12 to 14 days)**

F2. Patient Health Questionnaire (PHQ2) (cont.)

Enter Code

F2c. Feeling down, depressed, or hopeless?
- **0. No** *(If **No**, skip to question F3.)*
- **1. Yes**
- **8. Unable to respond** *(If **Unable**, skip to question F3.)*

Enter Code

F2d. If **Yes**, how many days in the last 2 weeks?
- **0. Not at all (0 to 1 days)**
- **1. Several days (2 to 6 days)**
- **2. More than half of the days (7 to 11 days)**
- **3. Nearly every day (12 to 14 days)**

F3. Feeling Sad: PAC Admission and Discharge

Enter Code

F3a. Ask patient: *"During the past 2 weeks, how often would you say, 'I feel sad'?"*
- **0. Never**
- **1. Rarely**
- **2. Sometimes**
- **3. Often**
- **4. Always**
- **8. Unable to respond**

IV. Cognitive Status, Mood & Pain (cont.)

G. Pain

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 Function
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. 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 at the 2-day assessment period.

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 this section? _____ (minutes)

V. Impairments

A. Bladder and Bowel Management: Use of Device(s) and Incontinence

Enter Code

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

	Bladder	Bowel
	Enter Code	Enter Code
A2. Does this patient use an **external or indwelling device** or require intermittent catheterization? **0. No** **1. Yes**	A2a. ☐	A2b. ☐
A3. Indicate the **frequency of incontinence** during the 2-day assessment period. **0. Continent** (no documented incontinence) **1. Stress incontinence only** (bladder only) **2. Incontinent less than daily** (only once during the 2-day assessment period) **3. Incontinent daily** (at least once a day) **4. Always incontinent** **5. No urine/bowel output during the 2-day assessment period** (e.g., renal failure)	A3a. ☐	A3b. ☐
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)? **0. No** **1. Yes**	A4a. ☐	A4b. ☐
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**	A5a. ☐	A5b. ☐

B. Swallowing

Enter Code

B1. Does the patient have any impairments with swallowing?
0. No *(If* **No** *impairments, skip to Section C. Hearing, Vision, and Communication.)*
1. Yes *(If* **Yes**, *please complete this section.)*

Check all that apply

B1. Swallowing Disorder: Signs and symptoms of 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) _____

B2. Swallowing: Describe the patient's usual ability with swallowing.

- ☐ **B2a. Regular food:** Solids and liquids swallowed safely without supervision and without modified food or liquid consistency.
- ☐ **B2b. Modified food consistency/supervision:** Patient requires modified food or liquid consistency and/or needs supervision during eating for safety.
- ☐ **B2c. Tube/parenteral feeding:** Tube/parenteral feeding used wholly or partially as a means of sustenance.

V. Impairments (cont.)

C. Hearing, Vision, and Communication

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

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**

V. Impairments (cont.)

D. Weight-bearing

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 in the 2-day assessment period.

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

E. Grip Strength

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 in the 2-day assessment period.

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

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

F. Respiratory Status

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** in the 2-day assessment period?

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**

V. Impairments (cont.)

G. Endurance

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) in the 2-day assessment period?
0. No, could not do
1. Yes, can do with rest
2. Yes, can do without rest
8. Not assessed due to medical counter indication

Enter Code

G1b. Sitting Endurance: Was the patient able to tolerate sitting for 15 minutes during the 2-day assessment period?
0. No
1. Yes, with support
2. Yes, without support
8. Not assessed due to medical counter indication

H. Mobility Devices and Aids Needed

Check all that apply

H1. Indicate all mobility devices and aids needed at time of assessment. (Check all that apply.)

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

T.V How long did it take you to complete this section? _____ *(minutes)*

VI. Functional Status: Usual Performance

A. Core Self Care: The core self care items should be completed on ALL patients.

Code the patient's most usual performance for the 2-day assessment period 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**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

→ **Enter Code in Boxes** →

Enter ☐ Code	**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.
Enter ☐ Code	**A2. Tube feeding:** The ability to manage all equipment/supplies related to obtaining nutrition.
Enter ☐ Code	**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.
Enter ☐ Code	**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.
Enter ☐ Code	**A5. Upper body dressing:** The ability to put on and remove shirt or pajama top. Includes buttoning three buttons.
Enter ☐ Code	**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 for ALL patients: Code the patient's most usual performance for the 2-day assessment period 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**
A. Task **attempted** but not completed
N. **Not applicable**
P. **Patient Refused**

Enter Code in Boxes

Enter Code	**B1. Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on side of bed with feet flat on the floor, no back support.
Enter Code	**B2. Sit to Stand:** The ability to safely come to a standing position from sitting in a chair or on the side of a bed.
Enter Code	**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.
Enter Code	**B4. Toilet Transfer:** The ability to safely get on and off a toilet or commode.

MODE OF MOBILITY

Enter Code →	**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.*)
Enter Code Enter Code Enter Code Enter Code →	**B5a. Select the longest distance the patient walks and code his/her level of independence (Level 1–6) on that distance (observe their performance):** **1. Walk 150 ft (45 m):** Once standing, can walk at least 150 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.
Enter Code Enter Code Enter Code Enter Code	**B5b. Select the longest distance the patient wheels and code his/her level of independence (Level 1–6) (observe their performance):** **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 only for patients who will need post-acute care to improve their functional ability or personal assistance following discharge.

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 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	
Enter ☐ Code	**C1. Wash Upper Body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.
Enter ☐ Code	**C2. Shower/bathe self:** The ability to bathe self in shower or tub, including washing and drying self. Does not include transferring in/out of tub/shower.
Enter ☐ Code	**C3. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
Enter ☐ Code	**C4. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
Enter ☐ Code	**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.
Enter ☐ Code	**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	
Enter ☐ Code	**C7.** Does this patient primarily use a wheelchair for mobility? **0. No** (*If* **No**, *code C7a–C7f.*) **1. Yes** (*If* **Yes**, *code C7f–C7h.*)
Enter ☐ Code	**C7a. 1 step (curb):** The ability to step over a curb or up and down one step.
Enter ☐ Code	**C7b. Walk 50 feet with two turns:** The ability to walk 50 feet and make two turns.
Enter ☐ Code	**C7c. 12 steps-interior:** The ability to go up and down 12 interior steps with a rail.
Enter ☐ Code	**C7d. Four steps-exterior:** The ability to go up and down 4 exterior steps with a rail.
Enter ☐ Code	**C7e. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass, gravel, ice or snow.
Enter ☐ Code	**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.
Enter ☐ Code	**C7g. Wheel short ramp:** Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters).
Enter ☐ Code	**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 (cont.): Complete only for patients who will need post-acute care to improve their functional ability or personal assistance following discharge.

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	**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.
Enter ☐ Code	**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.
Enter ☐ Code	**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.
Enter ☐ Code	**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.
Enter ☐ Code	**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.
Enter ☐ Code	**C13. Make light meal:** The ability to plan and prepare all aspects of a light meal such as bowl of cereal or sandwich and cold drink, or reheat a prepared meal.
Enter ☐ Code	**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.
Enter ☐ Code	**C15. Light shopping:** Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.
Enter ☐ Code	**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.
Enter ☐ Code	**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 this section? _____ *(minutes)*

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**

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.**

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.**

T.VIII How long did it take you to complete this section? _____ (minutes)

VIII. Discharge Status

A. Discharge Information: Items with an asterisk (*) relating to assistance/support needs and caregiver availability are also included in home health admission assessments.

A1. Discharge Date

_____/_____/_____
MM DD YYYY

A2. Attending Physician

A3. Discharge Location

Where will the patient be discharged to?

Enter Code

1. **Private residence**
2. **Other community-based residential setting** (e.g., assisted living residents, group home, adult foster care)
3. **Long-term care facility/nursing home**
4. **Skilled nursing facility** (SNF/TCU)
5. **Short-stay acute hospital** (IPPS)
6. **Long-term care hospital** (LTCH)
7. **Inpatient rehabilitation hospital or unit** (IRF)
8. **Psychiatric hospital or unit**
9. **Facility-based hospice**
10. **Other** (e.g., shelter, jail, no known address)
11. **Discharged against medical advice**

A4. * Frequency of Assistance at Discharge (or admission for HH)

How often will the patient require assistance (physical care or supervision) from a caregiver(s) or provider(s)?

Enter Code

1. Patient **does not require assistance**
2. **Weekly** or less (e.g., requires help with grocery shopping or errands, etc.)
3. **Less than daily** but more often than weekly
4. **Intermittently** and predictably during the day or night
5. **All night** but not during the day
6. **All day** but not at night
7. **24** hours per day, or standby services

A5. Caregiver(s) Availability

Was the discharge destination decision influenced by the availability of a family member or friend to provide assistance?

Enter Code

0. **No** *(If* **No,** *skip to Section B. Residential Information.)*
1. **Yes**

A6. Willing Caregiver(s)*

Does the patient have one or more willing caregiver(s)?

Enter Code

0. **No** *(If* **No,** skip to *Section B. Residential Information.)*
1. **Yes, confirmed by caregiver**
2. **Yes, confirmed only by patient**
9. **Unclear from patient; no confirmation from caregiver**

A7. Types of Caregiver(s)*

What is the relationship of the caregiver(s) to the patient?

Check all that apply

- a. **Spouse or significant other**
- b. **Child**
- c. **Other unpaid family member or friend**
- d. **Paid help**

B. Residential Information: Complete only if patient is discharged to a private residence or other community-based setting.

B1. * Patient Lives With at Discharge (or admission for HH)

Upon discharge (admission), who will the patient live with?

Check all that apply

- a. **Lives alone**
- b. **Lives with paid helper**
- c. **Lives with other(s)**
- d. **Unknown**

VIII. Discharge Status (cont.)

C. Support Needs/Caregiver Assistance*

Type of Assistance Needed Patient needs assistance with (check all that apply)		Support Needs/Caregiver Assistance (If patient needs assistance, check one on each row)			
		CG able	CG will need training and/or other supportive services	CG not likely to be able	CG ability unclear
☐ C1a	a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	☐ C2a	☐ C3a	☐ C4a	☐ C5a
☐ C1b	b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	☐ C2b	☐ C3b	☐ C4b	☐ C5b
☐ C1c	c. Medication administration (e.g., oral, inhaled, or injectable)	☐ C2c	☐ C3c	☐ C4c	☐ C5c
☐ C1d	d. Medical procedures/treatments (e.g., changing wound dressing)	☐ C2d	☐ C3d	☐ C4d	☐ C5d
☐ C1e	e. Management of equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment, or supplies)	☐ C2e	☐ C3e	☐ C4e	☐ C5e
☐ C1f	f. Supervision and safety	☐ C2f	☐ C3f	☐ C4f	☐ C5f
☐ C1g	g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	☐ C2g	☐ C3g	☐ C4g	☐ C5g
☐ C1h	h. None of the above				

VIII. Discharge Status (cont.)

D. Discharge Care Options

Please indicate whether the following services were considered appropriate for the patient at discharge; for those identified as potentially appropriate, were they: available, refused by family, or not covered by insurance. (Check all that apply.)

Type of Service	Considered Appropriate by the Provider	Bed/Services Available	Refused by Patient/Family	Not Covered by Insurance
a. **Home Health Care (HHA)**	☐ D1a	☐ D2a	☐ D3a	☐ D4a
b. **Skilled Nursing Facility (SNF)**	☐ D1b	☐ D2b	☐ D3b	☐ D4b
c. **Inpatient Rehabilitation Hospital (IRF)**	☐ D1c	☐ D2c	☐ D3c	☐ D4c
d. **Long-Term Care Hospital (LTCH)**	☐ D1d	☐ D2d	☐ D3d	☐ D4d
e. **Psychiatric Hospital**	☐ D1e	☐ D2e	☐ D3e	☐ D4e
f. **Outpatient Services**	☐ D1f	☐ D2f	☐ D3f	☐ D4f
g. **Acute Hospital Admission**	☐ D1g	☐ D2g	☐ D3g	☐ D4g
h. **Hospice**	☐ D1h	☐ D2h	☐ D3h	☐ D4h
i. **Long-term personal care services**	☐ D1i	☐ D2i	☐ D3i	☐ D4i
j. **LTC Nursing Facility**	☐ D1j	☐ D2j	☐ D3j	☐ D4j
k. **Other** (specify) _____	☐ D1k	☐ D2k	☐ D3k	☐ D4k

VIII. Discharge Status (cont.)

E. Discharge Location Information

Enter Code

E1. Is the patient being discharged with referral for additional services?

0. **No** (*If* **No,** skip to *E7. Discharge Delay.*)
1. **Yes** (*If* **yes,** *please identify the name, location, and type of service to which the patient is discharged.)*

E2. Provider's Name

E4. Provider City

Enter Code

E3. Provider Type

1. **Home Health Care (HHA)**
2. **Skilled Nursing Facility (SNF)**
3. **Inpatient Rehabilitation Hospital (IRF)**
4. **Long-Term Care Hospital (LTCH)**
5. **Psychiatric Hospital**
6. **Outpatient Services**
7. **Acute Hospital**
8. **Hospice**
9. **LTC Nursing Facility**
10. **Other** (specify) _____

E5. Provider State

E6. Medicare Provider's Identification Number

E7. Discharge Delay

Enter Code

Was the patient's discharge delayed for at least **24** hours?

0. **No**
1. **Yes**

E8. Reason for Discharge Delay

Enter Code

1. **No bed available**
2. **Services, equipment or medications not available** (e.g., home health care, durable medical equipment, IV medications)
3. **Family/support** (e.g., family could not pick patient up)
4. **Medical** (patient condition changed)
5. **Other** (specify)_____

E9. In the situation that the patient or an authorized representative has requested this information not be shared with the next provider, check here: ☐

T.IX How long did it take you to complete this section? _____ *(minutes)*

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 discharge or at the time of a significant change in the patient's status affecting Medicare payment.

A. Principal Diagnosis

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

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)

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 section)*
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
C1a.	|___|___|.|___|___|	C1b.	
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.	

Enter Code

C16. Is this list complete?

0. No
1. Yes

X. Other Useful Information

A1. 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.

APPENDIX C:
CARE TOOL ITEM MATRIX

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Table C-1
CARE tool item matrix

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
Attestation and Signatures of Persons who Completed a Portion of the Assessment						
Signatures	—	**C**	**C**	**C**	**C**	**C**
I. Administrative Items						
A. Assessment Type						
A1	Reason for Assessment	**C**	**C**	**C**	**C**	**C**
A2	Admission Date	**C**	**C**	**C**	**C**	**C**
A3	Assessment Reference Date	**C**	**C**	**C**	**C**	**C**
A4	Expired Date	—	—	—	—	**C**
B. Provider Information						
B1	Provider's Name	**C**	**C**	**C**	**C**	**C**
B2	Medicare Provider's Identification Number	**C**	**C**	**C**	**C**	**C**
B3	National Provider Identification Code (NPI)	**C**	**C**	**C**	**C**	**C**
C. Patient Information						
C1	Patient's First Name	**C**	**C**	**C**	**C**	**C**
C2	Patient's Middle Initial or Name	**C**	**C**	**C**	**C**	**C**
C3	Patient's Last Name	**C**	**C**	**C**	**C**	**C**
C4	Patient's Nickname (optional)	**C**	**C**	**C**	**C**	**C**
C5	Patient's Medicare Health Insurance Number	**C**	**C**	**C**	**C**	**C**
C6	Patient's Medicaid Number	**C**	**C**	**C**	**C**	**C**
C7	Patient's Identification Number/Provider Account Number	**C**	**C**	—	—	—
C8	Birth Date	**C**	**C**	—	—	—
C9	Social Security Number (optional)	**C**	**C**	—	—	—
C10	Gender	**C**	**C**	—	—	—
C11a-C11g	Race/Ethnicity	**C**	**C**	—	—	—
C12	Is English the patient's primary language?	**C**	**C**	—	—	—
C12a	If English is not the patient's primary language, what is the patient's primary language?	**C**	**C**	—	—	—
C12b	Does the patient want or need an interpreter (language or sign language) to communicate with a doctor or health care staff?	**C**	**C**	—	—	—

(continued)

Table C-1
CARE tool item matrix (continued)

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
D. Payer Information						
D1-D13	Current Payment Sources	**C**	**C**	**C**	**C**	—
T.I.	How long did it take you to complete this section?	—	—	—	—	—
II. Admission Information						
A. Pre-admission Service Use						
A1	Admission Date	**C**	**C**	—	—	—
A2	Admitted From	**C**	**C**	—	—	—
A3	Primary diagnosis in previous setting	**C**	**C**	—	—	—
A4a-A4i	Other Services in past 2 months	**C**	**C**	—	—	—
B. Patient History Prior To This Current Illness, Exacerbation, or Injury						
B1	Where did patient live	**C**	**C**	—	—	—
B2	If in community, Zip Code of Prior Residence	**C**	**C**	—	—	—
B3a-B3d	If in community, help used	**C**	**C**	—	—	—
B3aa-B3ad	If in the community, who did the patient live with?	**C**	**C**	—	—	—
B4a-B4f	Structural barriers	**C**	**C**	—	—	—
B5a-B5e	Prior Functioning	**C**	**C**	—	—	—
B6a-B6h	Mobility Devices	**C**	**C**	—	—	—
B7	History of Falls	**C**	**C**	—	—	—
T.II.	How long did it take you to complete this section?	—	—	—	—	—
III. Current Medical Information/Clinicans						
A. Primary Diagnosis						
A1	Primary Diagnosis at Assessment	**C**	**C**	**C**	**C**	**C**
B. Other Diagnoses, Comorbidites, and Complications						
B1-B15	Other Comorbidities	**C**	**C**	**C**	**C**	**C**
B16	Is this list complete?	**C**	**C**	**C**	**C**	**C**

(continued)

Table C-1
CARE tool item matrix (continued)

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions)	Did the patient have one or more major procedures (diagnostic, surgical, and therapeutic interventions) during this admission?	**C**	**C**	**C**	**C**	**C**
C1a-C15a	Procedures	**S**	**S**	**S**	**S**	**S**
C1b-C15b	Right	**S**	**S**	**S**	**S**	**S**
C1c-C15c	Left	**S**	**S**	**S**	**S**	**S**
C1d-C15d	Not applicable	**S**	**S**	**S**	**S**	**S**
C16	Is list complete?	**S**	**S**	**S**	**S**	**S**
D. Major Treatments						
D1a-D30a	Admitted/Discharged With	**C**	**C**	**C**	**C**	**C**
D1b-D30b	Used at Any Time During Stay	**C**	**—**	**C**	**C**	**C**
D9c	Specify reason for continuous monitoring	**S**	**S**	**S**	**S**	**S**
D11c	Specify most intensive frequency of suctioning during stay	**S**	**S**	**S**	**S**	**S**
D23c	Specify reason for 24-hour supervision	**S**	**S**	**S**	**S**	**S**
D30c	Other Major Treatments: Specify	**S**	**S**	**S**	**S**	**S**
E. Medications						
E1a-E30a	Medication Name	**C**	**C**	**C**	**C**	**C**
E1b-E30b	Dose	**C**	**C**	**C**	**C**	**C**
E1c-E30c	Route	**C**	**C**	**C**	**C**	**C**
E1d-E30d	Frequency	**C**	**C**	**C**	**C**	**C**
E1e-E30e	Planned Stop Date	**C**	**C**	**C**	**C**	**C**
E31	Is list complete?	**C**	**C**	**C**	**C**	**C**
F. Allergies and Adverse Drug Reactions						
F1	Any Known Allergies or Reactions?	**C**	**C**	**C**	**—**	**—**
F1a-F8a	Allergy/Cause of Reaction	**S**	**S**	**S**	**—**	**—**
F1b-F8b	Patient Reactions	**S**	**S**	**S**	**—**	**—**
F9	Is the list complete?	**S**	**S**	**S**	**—**	**—**

(continued)

Table C-1
CARE tool item matrix (continued)

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
G. Skin Integrity						
G1	Pressure Ulcer Risk	**C**	**C**	**C**	**C**	—
G2	Any Stage 2+ Pressure Ulcers?	**C**	**C**	**C**	**C**	—
G2a-G2d	Number present at assessment Number with onset during this service	**S**	**S**	**S**	**S**	—
G2e	If Stage 2 :Number of Unhealed	**S**	**S**	**S**	**S**	—
G3a	Longest length in any direction	**S**	**S**	**S**	**S**	—
G3b	Width of SAME unhealed ulcer or eschar	**S**	**S**	**S**	**S**	—
G3c	Date of measurement	**S**	**S**	**S**	**S**	—
G4	If Stage 3 or 4, Tunneling	**S**	**S**	**S**	**S**	—
G5	Any Major Wounds (excluding pressure ulcer)	**C**	**C**	**C**	**C**	—
G5a-G5e	Number and Type of Major Wounds	**S**	**S**	**S**	**S**	—
G6a-G6e	Turning surfaces not intact	**C**	**C**	**C**	**C**	—
H. Physiologic Factors						
H1a-H23a, H30a	Date	**C**	**C**	**C**	**C**	—
H1b-H22b, H24b-H29b, H31b-H42b	Value	**C**	**C**	**C**	**C**	—
H1c-H42c	Check if NOT tested	**C**	**C**	**C**	**C**	—
H1d-H4d	Estimated value	**C**	**C**	**C**	**C**	—
H10d	Specify source and amount of supplemental O2	**C**	**C**	**C**	**C**	—
H23d	Specify source and amount of supplemental O2	**C**	**C**	**C**	**C**	—
T.III.	How long did it take you to complete this section?	—	—	—	—	—
IV. Cognitive Status						
A. Comatose						
A1	Persistent vegetative state	**C**	**C**	—	—	—
B. Temporal Orientation and BIMS						
B1a	Interview attempted	**C**	**C**	—	—	—
B1b	Reason interview not attempted	**S**	**S**	—	—	—
B2a	Ask patient: “Please tell me what year it is right now.”	**C**	—	—	—	—
B2b	Ask patient: “What month are we in right now?	**C**	—	—	—	—
B3a	Repetition of three words	—	**C**	—	—	—

(continued)

Table C-1
CARE tool item matrix (continued)

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
B3b.1.	Ask patient: “Please tell me what year it is right now.”	—	**C**	—	—	—
B3b.2.	Ask patient: “What month are we in right now?	—	**C**	—	—	—
B3b.3.	Ask patient: “What day of the week is today?”	—	**C**	—	—	—
B3c.1.	Recalls “sock?”	—	**C**	—	—	—
B3c.2.	Recalls "blue?"	—	**C**	—	—	—
B3c.3.	Recalls "bed?"	—	—	—	—	—
C. Observational of Cognitive Status						
C1a-C1f	Memory/Recall Ability	**S**	**S**	—	—	—
D. Confusion Assessment Method						
D1	Inattention	**S**	**S**	—	—	—
D2	Disorganized thinking	**S**	**S**	—	—	—
D3	Altered level of consciousness/alertness	**S**	**S**	—	—	—
D4	Psychomotor retardation	**S**	**S**	—	—	—
E. Behavorial Signs and Symptoms						
E1	Physical	—	**C**	**C**	—	—
E2	Verbal	—	**C**	**C**	—	—
E3	Other	—	**C**	**C**	—	—
F. Mood						
F1	Interview attempted	—	**C**	**C**	—	—
F2a-F2d	PHQ2	—	**C**	**C**	—	—
F3	Feeling Sad	—	**C**	**C**	—	—
G. Pain						
G1	Interview attempted?	**C**	**C**	**C**	**C**	—
G2	Pain presence	**C**	**C**	**C**	**C**	—
G3	Pain severity 0-10	**S**	**S**	**S**	**S**	—
G4	Pain effect on function	**S**	**S**	**S**	**S**	—
G5	Limited activities because of pain	**S**	**S**	**S**	**S**	—
G6a-G6e	Observed Pain	**S**	**S**	**S**	**S**	—

(continued)

Table C-1
CARE tool item matrix (continued)

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
T.IV.	How long did it take you to complete this section?	—	—	—	—	—
V. Impairments						
A. Bladder and Bowel Management						
A1	Any impairments?	**C**	**C**	**C**	**C**	—
A2a-A2b	Use of external or indwelling device	**S**	**S**	**S**	**S**	—
A3a-A3b	Frequency of incontinence	**S**	**S**	**S**	**S**	—
A4a-A4b	Assistance managing bowel/bladder equipment	**S**	**S**	**S**	**S**	—
A5a-A5b	Incontinent prior to the current illness	**S**	**S**	**S**	**S**	—
B. Swallowing						
B1	Any impairments?	**C**	**C**	**C**	**C**	—
B1a-B1g	Swallowing: signs and symptoms	**S**	**S**	**S**	**S**	—
B2a-B2c	Swallowing: usual ability	**S**	**S**	**S**	**S**	—
C. Hearing, Vision, Communication, & Comprehension						
C1	Any impairments?	**C**	**C**	**C**	**C**	—
C1a	Understanding verbal content	**S**	**S**	**S**	**S**	—
C1b	Expression of ideas and wants	**S**	**S**	**S**	**S**	—
C1c	Ability to see in adequate light	**S**	**S**	**S**	**S**	—
C1d	Ability to hear	**S**	**S**	**S**	**S**	—
D. Weight-bearing						
D1	Any impairments?	**C**	**C**	**C**	**C**	—
D1a-D1d	Weight-bearing upper and lower extremities	**S**	**S**	**S**	**S**	—
E. Grip Strength						
E1	Any impairments?	**C**	**C**	**C**	**C**	—
E1a-E1b	Grip strength right and left hands	**S**	**S**	**S**	**S**	—
F. Respiratory Status						
F1	Any impairments?	**C**	**C**	**C**	**C**	—
F1a-F1b	Respiratory Status	**S**	**S**	**S**	**S**	—
G. Endurance						
G1	Any impairments?	**C**	**C**	**C**	**C**	—

(continued)

Table C-1
CARE tool item matrix (continued)

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
G1a	Mobility Endurance	**S**	**S**	**S**	**S**	**—**
G1b	Sitting Endurance	**S**	**S**	**S**	**S**	**—**
H. Mobility Devices and Aids Needed						
H1a-H1h	Indicate all mobility and aids needed	**C**	**C**	**C**	**C**	**—**
T.V.	How long did it take you to complete this section?	**—**	**—**	**—**	**—**	**—**
VI. Functional Status						
A. Self Care						
A1	Eating	**C**	**C**	**C**	**C**	**—**
A2	Tube Feeding	**C**	**C**	**C**	**C**	**—**
A3	Oral Hygiene	**C**	**C**	**C**	**C**	**—**
A4	Toilet Hygiene	**C**	**C**	**C**	**C**	**—**
A5	Upper Body Dressing	**C**	**C**	**C**	**C**	**—**
A6	Lower Body dressing	**C**	**C**	**C**	**C**	**—**
B. Core Functional Mobility						
B1	Lying to Sitting on Side of Bed	**C**	**C**	**C**	**C**	**—**
B2	Sit to Stand	**C**	**C**	**C**	**C**	**—**
B3	Chair/Bed-to-Chair Transfer	**C**	**C**	**C**	**C**	**—**
B4	Toilet Transfer	**C**	**C**	**C**	**C**	**—**
B5	Mode of Mobility	**C**	**C**	**C**	**C**	**—**
B5a	Longest distance patient can walk	**C**	**C**	**C**	**C**	**—**
B5b	Longest distance patient can wheel	**C**	**C**	**C**	**C**	**—**
C. Supplemental Functional Ability: Code patient on all activities that the patient can participate in and which you can observe.						
C1	Wash upper body	**S**	**S**	**S**	**S**	**—**
C2	Shower/bathe self	**S**	**S**	**S**	**S**	**—**
C3	Roll Left and Right	**S**	**S**	**S**	**S**	**—**
C4	Sit to Lying	**S**	**S**	**S**	**S**	**—**
C5	Picking up object	**S**	**S**	**S**	**S**	**—**
C6	Putting on/taking off footwear	**S**	**S**	**S**	**S**	**—**

(continued)

Table C-1
CARE tool item matrix (continued)

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
C7	Mode of Mobility: Wheelchair?	**S**	**S**	**S**	**S**	—
C7a	One Step (curb)	**S**	**S**	**S**	**S**	—
C7b	Walk 50 feet with 2 turns	**S**	**S**	**S**	**S**	—
C7c	12 steps-interior	**S**	**S**	**S**	**S**	—
C7d	4 steps-exterior	**S**	**S**	**S**	**S**	—
C7e	Walking 10 feet on uneven surfaces	**S**	**S**	**S**	**S**	—
C7f	Car transfer	**S**	**S**	**S**	**S**	—
C7g	Wheel short ramp	**S**	**S**	**S**	**S**	—
C7h	Wheel long ramp	**S**	**S**	**S**	**S**	—
C8	Telephone-answering	**S**	**S**	**S**	**S**	—
C9	Telephone-Placing Call	**S**	**S**	**S**	**S**	—
C10	Medication Management-Oral Medications	**S**	**S**	**S**	**S**	—
C11	Medication Management-Inhalant/Mist Medications	**S**	**S**	**S**	**S**	—
C12	Medication Management-Injectable Medications	**S**	**S**	**S**	**S**	—
C13	Make light meal	**S**	**S**	**S**	**S**	—
C14	Wipe down surface	**S**	**S**	**S**	**S**	—
C15	Light shopping	**S**	**S**	**S**	**S**	—
C16	Laundry	**S**	**S**	**S**	**S**	—
C17	Use Public Transportation	**S**	**S**	**S**	**S**	—
T.VI.	How long did it take you to complete this section?	—	—	—	—	—
VII. Overall Plan of Care/Advance Care Directives						
A.Overall Plan of Care/ Advance Care Directives	Documented agreed-upon care goals and					
A1	expected dates of completion	**C**	**C**	**C**	**C**	—
A2	Description of overall status	**C**	**C**	**C**	**C**	—
A3	Documented care decisions	**C**	**C**	**C**	**C**	—
T.VII.	How long did it take you to complete this section?	—	—	—	—	—

(continued)

Table C-1
CARE tool item matrix (continued)

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
VIII. Discharge Status						
A. Discharge Information						
A1	Discharge date	**C**	**—**	**C**	**—**	**—**
A2	Attending Physician	**C**	**—**	**C**	**—**	**—**
A3	Discharge location	**C**	**—**	**C**	**—**	**—**
A4	Frequency of Assistance at Discharge	**C**	**C**[1]	**C**	**—**	**—**
A5	Caregiver Availability	**C**	**—**	**C**	**—**	**—**
A6	Willing Caregiver(s)	**S**	**C**[1]	**S**	**—**	**—**
A7	Types of Caregiver(s)	**S**	**C**[1]	**S**	**—**	**—**
B. Caregiver Information						
B1	Patient lives with	**S**	**—**	**S**	**—**	**—**
C. Support Needs/Caregiver Assistance						
C1a-C1h	Patient needs this	**S**	**C**[1]	**S**	**—**	**—**
C2a-C2g	Caregiver able	**S**	**C**[1]	**S**	**—**	**—**
C3a-C3g	Caregiver needs training or other supportive services	**S**	**C**[1]	**S**	**—**	**—**
C4a-C4g	Caregiver not likely to be able	**S**	**C**[1]	**S**	**—**	**—**
C5a-C5g	Caregiver ability unclear	**S**	**C**[1]	**S**	**—**	**—**
D. Discharge Care Options						
D1a-D1k	Deemed Appropriate by the Provider	**C**	**—**	**C**	**—**	**—**
D2a-D2k	Bed/Services Available	**C**	**—**	**C**	**—**	**—**
D3a-D3k	Refused by Patient/Family	**C**	**—**	**C**	**—**	**—**
D4a-D4k	Not Covered by Insurance	**C**	**—**	**C**	**—**	**—**
E. Discharge Location Information						
E1	Discharged with referral	**C**	**—**	**C**	**—**	**—**
E2	Provider Name	**S**	**—**	**S**	**—**	**—**
E3	Provider Type	**S**	**—**	**S**	**—**	**—**
E4	Provider City	**S**	**—**	**S**	**—**	**—**
E5	Provider State	**S**	**—**	**S**	**—**	**—**
E6	Medicare Provider Identification Number	**S**	**—**	**S**	**—**	**—**
E7	Discharge delay	**S**	**—**	**S**	**—**	**—**

(continued)

Table C-1
CARE tool item matrix (continued)

Item number	Item description	Acute hospital discharge	PAC admission	PAC discharge	Interim	Expired
E8	Reason for Discharge Delay	**S**	**—**	**S**	**—**	**—**
E9	Patient requests that information not be shared	**S**	**—**	**S**	**—**	**—**
T.IX.	How long did it take you to complete this section?	**—**	**—**	**—**	**—**	**—**
IX. Medical Coding Information						
A. Principal Diagnosis						
A1	ICD-9 CM Code for Principal Diagnosis	**C**	**C**	**C**	**C**	**C**
A1a	Principal Diagnosis at Assessment	**C**	**C**	**C**	**C**	**C**
A2	ICD-9 CM Code for Principal Diagnosis if it was a V-code	**S**	**S**	**S**	**S**	**S**
A2a	If principal diagnosis was a V-code was was the primary medical condition or injury being treated	**S**	**S**	**S**	**S**	**S**
B. Other Diagnoses, Combordities, and Complications						
B1a-B15a	ICD-9 CM Code	**C**	**C**	**C**	**C**	**C**
B1b-B15b	Diagnosis	**C**	**C**	**C**	**C**	**C**
B16	Is this list complete?	**C**	**C**	**C**	**C**	**C**
C. Major Procedures (Diagnostic, Surgical, and Therapeutic Interventions)						
C1	One or more major procedure	**C**	**C**	**C**	**C**	**C**
C1a-C15a	ICD-9 CM Code	**S**	**S**	**S**	**S**	**S**
C1b-C15b	Procedure	**S**	**S**	**S**	**S**	**S**
C16	Is this list complete?	**S**	**S**	**S**	**S**	**S**
X. Other Useful Information						
A1	Other useful information about this patient	**S**	**S**	**S**	**S**	**S**
XI. Feedback						
A1	Notes	**S**	**S**	**S**	**S**	**S**

[1] These items are included in home health admission assessments.
NOTE: C = core. S = supplemental.

APPENDIX D:
RESPONSES TO SKIP-LOGIC QUESTIONS

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Table D-1
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
Frequency	—	—	**102**	**122**	**65**	**103**	**100**	**45**	**5**	**30**	**9**	**581**	—
III. Current Medical Items													
IIIC1. Did the patient have one or more diagnostic or therapeutic procedures during this admission?	One or More Procedures. Responding Yes	"Yes" Responses	72	—	16	—	54	—	—	—	—	142	—
—	—	Total Responses	84	1	32	0	82	0	2	1	2	204	—
—	—	% "Yes" Responses	86	—	50	—	66	—	—	—	—	70	—
IIIC1a. Procedure	Percent missing of those Responding Yes to IIIC1 (One+ Procedures)	Expected Responses	71	—	9	—	26	—	—	—	—	106	—
—	—	Total Responses	86	0	13	0	26	0	1	0	1	127	83
—	—	% missing	1	—	44	—	52	—	—	—	—	—	—
Pressure Ulcers IIID1b. Does the patient have Pressure Ulcers?	Does Patient Have Pressure Ulcers. Responding Yes	"Yes" Responses	3	43	24	15	11	6	1	2	—	105	—
—	—	Total Responses	93	99	57	96	92	44	4	26	8	519	—
—	—	% "Yes" Responses	3	43	42	16	12	14	25	8	—	20	—
D2. Number of Pressure Ulcers IIIG1b. Unhealed Pressure Ulcers Present	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	2	36	20	13	9	6	1	1	—	88	—
—	—	Total Responses	5	67	41	20	18	24	1	2	1	179	49
—	—	% missing	33	16	17	13	18	0	0	50	—	—	—
IIIG2a.	# of Unhealed Stage 2 Ulcers. Responding Yes to IIIG1B and > 0 to IIIG2A	Responses > 0	2	36	20	13	9	6	1	1	—	88	—
—	—	"Yes" Responses	3	43	24	15	11	6	1	2	—	105	—
—	—	% Responses > 0	67	84	83	87	82	100	100	50	—	84	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
IIIG2b. Number of Pressure Ulcers Discovered During This Admission	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	0	18	0	8	0	0	0	—	29	—
—	—	Total Responses	4	0	38	0	17	0	0	0	1	60	48
—	—	% missing	0	—	25	—	27	—	100	—	—	—	—
IIIG2c. Unhealed Pressure Ulcers Present	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	2	34	17	8	5	6	1	2	—	75	—
—	—	Total Responses	2	65	37	15	11	24	1	3	0	158	47
—	—	% missing	33	21	29	47	55	0	0	0	—	—	—
IIIG2c.	# of Unhealed Stage 3 or 4 Ulcers. Responding Yes to IIIG1B and > 0 to IIIG2C or IIIG2E	Responses > 0	2	38	20	8	5	6	1	2	—	82	—
—	—	"Yes" Responses	3	43	24	15	11	6	1	2	—	105	—
—	—	% Responses > 0	67	88	83	53	45	100	100	100	—	78	—
IIIG2d. Number of Pressure Ulcers Discovered During This Admission	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	0	14	0	4	0	0	0	—	21	—
—	—	Total Responses	3	0	33	0	10	0	0	0	0	46	46
—	—	% missing	0	—	42	—	64	—	—	—	—	—	—
IIIG2e. Unhealed Pressure Ulcers Present	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	2	37	18	6	3	6	1	2	—	75	—
—	—	Total Responses	2	68	38	13	9	24	1	3	0	158	47
—	—	% missing	33	14	25	60	73	0	0	0	—	—	—
IIIG2e.	# of Unhealed Stage 3 or 4 Ulcers. Responding Yes to IIIG1B and > 0 to IIIG2C or IIIG2E	Responses > 0	2	38	20	8	5	6	1	2	—	82	—
—	—	"Yes" Responses	3	43	24	15	11	6	1	2	—	105	—
—	—	% Responses > 0	67	88	83	53	45	100	100	100	—	78	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
IIIG2f. Number of Pressure Ulcers Discovered During This Admission	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	0	16	0	3	0	0	0	—	22	—
—	—	Total Responses	3	0	35	0	9	0	0	0	0	47	47
—	—	% missing	0	—	33	—	73	—	—	—	—	—	—
IIIG2g. Unhealed Pressure Ulcers Present	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	38	15	8	4	6	1	2	—	77	—
—	—	Total Responses	3	68	36	15	10	24	1	3	0	160	48
—	—	% missing	0	12	38	47	64	0	0	0	—	—	—
G2h. Number of Pressure Ulcers Discovered During This Admission	Percent missing of those Responding Yes to IIIG1B (Pressure Ulcers)	Expected Responses	3	0	14	0	4	0	0	0	—	21	—
—	—	Total Responses	3	0	34	0	9	0	0	0	0	46	46
—	—	% missing	0	—	42	—	64	—	—	—	—	—	—
IIIG3. Number of unhealed	Percent missing of those Responding > 0 to IIIG2A (Number of Unhealed Stage 2)	Expected Responses	2	44	31	12	8	21	1	1	1	121	—
—	—	Total Responses	3	53	35	16	10	21	1	3	1	143	85
—	—	% missing	60	34	24	40	56	13	0	50	0	—	—
D4. Longest IIIG4a. Enter Length in cm	Percent missing of those Responding > 0 to IIIG2C or IIIG2E (Number of Unhealed Stage 3 or 4)	Expected Responses	0	47	26	4	2	8	1	0	—	88	76
—	—	Total Responses	2	61	38	4	2	8	1	0	0	116	—
—	—	% missing	—	32	35	73	82	67	0	—	—	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
IIIG4b. Enter Width in cm	Percent missing of those Responding > 0 to IIIG2C or IIIG2E (Number of Unhealed Stage 3 or 4)	Expected Responses	0	47	26	4	2	1	0	—	—	80	74
—	—	Total Responses	2	61	38	4	2	1	0	0	—	108	—
—	—	% missing	—	32	35	73	82	0	100	—	—	—	—
IIIG5. Presence of Tunneling	Percent missing of those Responding > 0 to IIIG2C or IIIG2E (Number of Unhealed Stage 3 or 4)	Expected Responses	0	60	33	10	4	17	1	1	—	126	—
—	—	Total Responses	2	67	37	15	15	17	1	2	0	156	81
—	—	% missing	—	13	18	33	64	29	0	67	—	—	—
IV. Cognitive Status ***B. BIMS***	Interview Attempted. Responding No												
IVB1. Interview Attempted		"No" Responses	9	37	33	5	33	4	—	2	2	125	—
—	—	Total Responses	94	96	53	90	97	42	2	26	9	509	—
—	—	% "No" Responses	10	39	62	6	34	10	—	8	22	25	—
IVB1. Interview Attempted	Interview Attempted. Responding Yes	"Yes" Responses	85	59	20	85	64	38	2	24	7	384	—
—	—	Total Responses	94	96	53	90	97	42	2	26	9	509	—
—	—	% "Yes" Responses	90	61	38	94	66	90	100	92	78	75	—
IVB1a. Indicate reason that BIMS interview was not attempted and then SKIP to C, Observational Assessment	Percent missing of those Responding No to IVB1 (Interview Attempted)	Expected Responses	6	28	22	5	30	2	—	1	2	96	—
—	—	Total Responses	9	37	23	9	38	3	0	1	2	122	79
—	—	% missing	33	24	33	0	9	50	—	50	0	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
IVB2. Repetition of Three Words	Percent missing of those Responding Yes to IVB1 (Interview Attempted)	Expected Responses	84	52	18	84	63	38	2	24	7	372	—
—	—	Total Responses	87	55	20	91	64	40	2	25	7	391	95
—	—	% missing	1	12	10	1	2	0	0	0	0	—	—
B3. Temporal Orientation IVB3a. Ask patient: "Please tell me what year it is right now."	Percent missing of those Responding Yes to IVB1 (Interview Attempted)	Expected Responses	84	52	18	83	60	38	2	23	6	366	—
—	—	Total Responses	88	56	20	90	61	41	2	24	6	388	94
—	—	% missing	1	12	10	2	6	0	0	4	14	—	—
IVB3b. Ask patient: "What month are we in right now?	Percent missing of those Responding Yes to IVB1 (Interview Attempted)	Expected Responses	84	52	18	81	62	38	2	23	6	366	—
—	—	Total Responses	88	56	20	88	63	41	2	24	6	388	94
—	—	% missing	1	12	10	5	3	0	0	4	14	—	—
B4. Recall IVB4. Recalls "sock"?	Percent missing of those Responding Yes to IVB1 (Interview Attempted)	Expected Responses	82	52	18	83	63	38	2	23	7	368	—
—	—	Total Responses	86	55	20	90	64	40	2	24	7	388	95
—	—	% missing	4	12	10	2	2	0	0	4	0	—	—
IVB5. Recalls "blue"?	Percent missing of those Responding Yes to IVB1 (Interview Attempted)	Expected Responses	83	52	18	83	64	38	2	23	7	370	—
—	—	Total Responses	87	55	20	90	65	40	2	24	7	390	95
—	—	% missing	2	12	10	2	0	0	0	4	0	—	—
IVB6. Recalls "bed"?	Percent missing of those Responding Yes to IVB1 (Interview Attempted)	Expected Responses	84	52	18	83	64	38	2	22	7	370	—
—	—	Total Responses	88	55	20	90	65	40	2	23	7	390	95
—	—	% missing	1	12	10	2	0	0	0	8	0	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
C. Observational Assessment													
IVC1. Short-Term Memory	Percent missing of those Responding No to IVB1 (Interview Attempted)	Expected Responses	4	17	20	2	22	2		2	2	71	—
—	—	Total Responses	28	41	30	25	30	39	2	21	8	224	32
—	—	% missing	56	54	39	60	33	50		0	0	—	—
IVC2. Long-Term Memory	Percent missing of those Responding No to IVB1 (Interview Attempted)	Expected Responses	5	17	20	2	19	2		2	2	69	—
—	—	Total Responses	28	41	30	26	26	39	2	21	8	221	31
—	—	% missing	44	54	39	60	42	50		0	0	—	—
IVC3. Memory/Recall Ability	Percent missing of those Responding No to IVB1 (Interview Attempted)	Expected Responses	7	29	21	4	24	4		2	1	92	—
—	—	Total Responses	31	62	30	26	33	43	2	21	6	254	36
—	—	% missing	22	22	36	20	27	0		0	50	—	—
IVC4. Cognitive Skills for Daily Decision Making	Percent missing of those Responding No to IVB1 (Interview Attempted)	Expected Responses	7	28	22	4	24	4		2	1	92	—
—	—	Total Responses	27	61	32	22	31	41	2	17	5	238	39
—	—	% missing	22	24	33	20	27	0		0	50	—	—
F. Mood													
IVF1. Mood Interview Attempted?	Percent missing of those Responding No to IVA1 (Comatose)	Expected Responses	82	84	48	85	96	39	2	24	8	468	—
—	—	Total Responses	91	98	50	91	97	40	2	26	8	503	93
—	—	% missing	5	2	9	6	1	7	0	0	11	—	—
—	Mood Interview Attempted. Responding Yes	"Yes" Responses	83	49	19	71	61	27	1	25	7	343	—
—	—	Total Responses	91	98	50	91	97	40	2	26	8	503	—
—	—	% "Yes" Responses	91	50	38	78	63	68	50	96	88	68	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
F2. PHQ 2													
IVF2a. Little interest or pleasure in doing things	Percent missing of those Responding Yes to IVF1 (Mood Interview)	Expected Responses	83	49	18	70	59	27	1	25	7	339	—
—	—	Total Responses	90	62	28	78	65	33	2	26	8	392	86
—	—	% missing	0	0	5	1	3	0	0	0	0	—	—
—	Little Interest in Doing Things. Responding Yes	"Yes" Responses	26	17	7	20	15	9		11	—	105	—
—	—	Total Responses	90	62	28	78	65	33	2	26	8	392	—
—	—	% "Yes" Responses	29	27	25	26	23	27		42	—	27	—
IVF2b. If Yes, How many days in the last 2 weeks?	Percent missing of those Responding Yes to IVF2A (Little Interest)	Expected Responses	24	17	7	16	14	9		11	—	98	—
—	—	Total Responses	31	25	10	22	19	10	0	16	0	133	74
—	—	% missing	8	0	0	20	7	0		0	—	—	—
IVF2c. Feeling down, depressed or hopeless	Percent missing of those Responding Yes to IVF1 (Mood Interview)	Expected Responses	79	48	17	66	55	27	1	25	7	325	—
—	—	Total Responses	87	63	30	78	60	34	2	26	7	387	84
—	—	% missing	5	2	11	7	10	0	0	0	0	—	—
IVF2c. Feeling down, depressed or hopeless	Feeling Down. Responding Yes	"Yes" Responses	31	27	11	27	27	14	1	9	—	147	—
—	—	Total Responses	87	63	30	78	60	34	2	26	7	387	—
—	—	% "Yes" Responses	36	43	37	35	45	41	50	35	—	38	—
IVF2d. If Yes, How many days in the last 2 weeks?	Percent missing of those Responding Yes to IVF2CA (Feeling Down)	Expected Responses	31	27	11	27	25	14	1	9	—	145	—
—	—	Total Responses	35	37	16	30	33	14	1	13	1	180	81
—	—	% missing	0	0	0	0	7	0	0	0	—	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
F3. Feeling Sad IVF3. Feeling Sad: Ask patient: "During the past 2 weeks, how often would you say, 'I feel sad?'"	Percent missing of those Responding Yes to IVF1 (Mood Interview)	Expected Responses	81	47	18	69	59	26	1	25	7	333	—
—	—	Total Responses	88	63	26	81	65	34	1	26	7	391	85
—	—	% missing	2	4	5	3	3	4	0	0	0	—	—
G. Fatigue Items IVG1. Fatigue Interview Attempted?	Percent missing of those Responding No to IVA1 (Comatose)	Expected Responses	86	85	41	80	94	39	2	24	7	458	—
—	—	Total Responses	95	99	43	86	96	40	2	26	7	494	93
—	—	% missing	0	1	23	11	3	7	0	0	22	—	—
IVG1. Fatigue Interview Attempted?	Fatigue Interview Attempted. Responding Yes	"Yes" Responses	81	42	16	43	37	22	1	20	7	269	—
—	—	Total Responses	95	99	43	86	96	40	2	26	7	494	54
—	—	% "Yes" Responses	85	42	37	50	39	55	50	77	100	—	—
IVG2. Ask patient “During the past 2 days, how often have you had trouble finishing things because of your fatigue?”	Percent missing of those Responding Yes to IVG1 (Fatigue Interview)	Expected Responses	81	41	16	42	37	22	1	20	7	267	—
—	—	Total Responses	86	52	25	53	40	25	1	21	7	310	86
—	—	% missing	0	2	0	2	0	0	0	0	0	—	—
H. Pain IVH1. Pain Interview Attempted?	Percent missing of those Responding No to IVA1 (Comatose)	Expected Responses	86	82	47	90	91	41	2	24	9	472	—
—	—	Total Responses	95	96	50	96	93	44	4	26	9	513	92
—	—	% missing	0	5	11	0	6	2	0	0	0	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
IVH1. Pain Interview Attempted?	Pain Interview Attempted. Responding Yes	"Yes" Responses	78	75	22	89	76	40	4	22	7	413	—
—	—	Total Responses	95	96	50	96	93	44	4	26	9	513	81
—	—	% "Yes" Responses	82	78	44	93	82	91	100	85	78	—	—
IVH1. Pain Interview Attempted?	Pain Interview Attempted. Responding No	"No" Responses	78	75	22	89	76	40	4	22	7	413	—
—	—	Total Responses	95	96	50	96	93	44	4	26	9	513	81
—	—	% "No" Responses	82	78	44	93	82	91	100	85	78	—	—
IVH2. Pain Presence	Percent missing of those Responding Yes to IVH1 (Pain Interview)	Expected Responses	78	75	22	88	75	40	4	22	7	411	—
—	—	Total Responses	81	87	29	91	80	42	4	23	7	444	93
—	—	% missing	0	0	0	1	1	0	0	0	0	—	—
IVH3. Pain Severity-scale	Percent missing of those Responding Yes to IVH1 (Pain Interview)	Expected Responses	65	40	16	67	58	23	1	17	4	291	—
—	—	Total Responses	67	49	19	69	62	24	1	17	4	312	93
—	—	% missing	17	47	27	25	24	43	75	23	43	—	—
IVH4. Pain Severity-intensity	Percent missing of those Responding Yes to IVH1 (Pain Interview)	Expected Responses	63	40	17	65	53	23	1	17	3	282	—
—	—	Total Responses	65	50	21	67	57	24	1	17	3	305	92
—	—	% missing	19	47	23	27	30	43	75	23	57	—	—
IVH5a. Pain Effect on Function	Percent missing of those Responding Yes to IVH1 (Pain Interview)	Expected Responses	65	42	17	64	51	25	1	17	3	285	—
—	—	Total Responses	67	50	21	67	55	26	1	17	3	307	93
—	—	% missing	17	44	23	28	33	38	75	23	57	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
IVH5b. Ask patient: "During the past 2 days, have you limited your day-to-day activities because of pain?"	Percent missing of those Responding Yes to IVH1 (Pain Interview)	Expected Responses	64	42	16	62	50	25	1	17	3	280	—
—	—	Total Responses	66	50	20	65	54	26	1	17	3	302	93
—	—	% missing	18	44	27	30	34	38	75	23	57	—	—
IVH6. Pain Observational Assessment--If patient does not or cannot respond to questions about pain	Percent missing of those Responding No to IVH1 (Pain Interview)	Expected Responses	6	24	1	21	9	21	0	2	0	84	—
—	—	Total Responses	17	45	17	25	14	23	0	3	2	146	58
—	—	% missing	92	68	95	76	88	48	—	91	—	—	—
V. Impairments *Bladder and Bowel Management* VA2a. Bladder	Percent missing of those Responding No to VA1B (Bowel Incontinence)	Expected Responses	85	36	26	83	90	40	3	24	8	395	—
—	—	Total Responses	86	69	39	88	92	44	3	24	8	453	87
—	—	% missing	11	27	19	7	6	0	25	8	11	—	—
VA2b. Bowel	Percent missing of those Responding No to VA1B (Bowel Incontinence)	Expected Responses	90	41	31	88	96	40	4	26	8	424	—
—	—	Total Responses	91	83	53	94	99	44	4	26	8	502	84
—	—	% missing	5	16	3	1	0	0	0	0	11	—	—
VI. Functional Status *B. Functional Mobility* VIB7. Mode of Mobility: Wheelchair?	Mode of Mobility: Wheelchair. Responding Yes	"Yes" Responses	5	10	7	25	15	31	2	2	—	97	—
—	—	Total Responses	90	64	56	91	96	41	2	22	9	471	21
—	—	% "Yes" Responses	6	16	13	27	16	76	100	9	—	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
VIB8. Wheelchair Users Only: Wheel 50 ft.	Percent missing of those Responding Yes to VIB7 (Mode of Mobility: Wheelchair)	Expected Responses	5	1	2	16	13	27	2	2	—	68	—
—	—	Total Responses	54	1	30	21	18	27	2	3	0	156	44
—	—	% missing	0	90	71	36	13	13	0	0	—	—	—
VIB8b. Wheelchair Users Only: Wheel 50 ft--If not attempted	Percent missing of those Responding Yes to VIB7 (Wheelchair)	Expected Responses	5	10	5	16	10	24	0	1	—	71	—
—	—	Total Responses	86	88	35	71	61	30	0	10	1	382	19
—	—	% missing	0	0	29	36	33	23	—	50	—	—	—
VIB9. Wheelchair Users Only: Wheel in Room Once Seated	Percent missing of those Responding Yes to VIB7 (Wheelchair)	Expected Responses	5	1	2	22	13	29	2	2	—	76	—
—	—	Total Responses	52	1	31	26	17	29	2	3	0	161	47
—	—	% missing	0	90	71	12	13	6	0	0	—	—	—
VII. Discharge Status	Discharge Location. Responding 1 or 2												
VIIB1. Discharge location		"1" or "2" Responses	45	—	3	—	68	—	1	—	8	125	—
—	—	Total Responses	96	0	37	0	97	0	2	0	9	241	52
—	—	% "1" or "2" Responses	47	—	8	—	70	—	50	—	89	—	—
VIIB1. Discharge location	Discharge Location. Responding 1, 2, or 8	"1," "2," or "8" Responses	46	—	4	—	68	—	1	—	8	127	—
—	—	Total Responses	96	0	37	0	97	0	2	0	9	241	53
—	—	% "1," "2," or "8" Responses	48	—	11	—	70	—	50	—	89	—	—
VIIB1. Discharge location	Discharge Location. Responding 3-7, or 9	"3," "7," or "9" Responses	50	—	26	—	24	—	1	—	1	102	—
—	—	Total Responses	96	0	37	0	97	0	2	0	9	241	42
—	—	% "3," "7," or "9" Responses	52	—	70	—	25	—	50	—	11	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
VIIB2. Home situation	Percent missing of those Responding 1 or 2 to VIIB1 (Discharge Location)	Expected Responses	42	—	3	—	65	—	1	—	7	118	—
—	—	Total Responses	62	0	7	0	91	0	2	0	8	170	69
—	—	% missing	7	—	0	—	4	—	0	—	13	—	—
C. Patient Needs Assistance VIIC1. Patient Lives with at Discharge	Percent missing of those Responding 1, 2, or 8 to VIIB1 (Discharge Location)	Expected Responses	46	—	2	—	65	—	1	—	8	122	—
—	—	Total Responses	47	0	2	0	70	0	1	0	9	129	95
—	—	% missing	0	—	50	—	4	—	0	—	0	—	—
VIIC2. Frequency of Assistance	Percent missing of those Responding 1, 2, or 8 to VIIB1 (Discharge Location)	Expected Responses	45	—	3	—	66	—	1	—	8	123	—
—	—	Total Responses	48	0	7	0	77	0	1	0	8	141	87
—	—	% missing	2	—	25	—	3	—	0	—	0	—	—
VIIC3. Caregiver(s) Availability	Percent missing of those Responding 1, 2, or 8 to VIIB1 (Discharge Location)	Expected Responses	43	—	3	—	64	—	1	—	6	117	—
—	—	Total Responses	45	0	8	0	76	0	1	0	6	136	86
—	—	% missing	7	—	25	—	6	—	0	—	25	—	—
VIIC4. Types of Caregives	Percent missing of those Responding 1, 2, or 8 to VIIB1 (Discharge Location)	Expected Responses	42	—	2	—	62	—	1	—	6	113	—
—	—	Total Responses	44	0	2	0	71	0	1	0	6	124	91
—	—	% missing	9	—	50	—	9	—	0	—	25	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
VIIC5a. Patient able to pay for meds after discharge	Percent missing of those Responding 1, 2, or 8 to VIIB1 (Discharge Location)	Expected Responses	41	—	3	—	65	—	1	—	7	117	—
—	—	Total Responses	51	0	10	0	81	0	2	0	7	151	77
—	—	% missing	11	—	25	—	4	—	0	—	13	—	—
VIIC5b. Patients mode of transport to aftercare following discharge	Percent missing of those Responding 1, 2, or 8 to VIIB1 (Discharge Location)	Expected Responses	42	—	2	—	61	—	1	—	7	113	—
—	—	Total Responses	50	0	6	0	75	0	2	0	7	140	81
—	—	% missing	9	—	50	—	10	—	0	—	13	—	—
VIIC5b. Patients mode of transport to aftercare following discharge	Patients Mode of Transport to Aftercare. Responding 5	"5" Responses	1	—	2	—	11	—	—	—	—	14	—
—	—	Total Responses	50	0	6	0	75	0	2	0	7	140	10
—	—	% "5" Responses	2	—	33	—	15	—	—	—	—	—	—
QVIIC6. If Transportation Other, Please specify mode:	Percent missing of those Responding 5 to VIIC5B (Mode of Transport to Aftercare)	Expected Responses	0	—	0	—	7	—		—		7	—
—	—	Total Responses	1	0	1	0	13	0	0	0	0	15	47
—	—	% missing	100	—	100	—	36	—		—		—	—
D. Discharge Care Options VIID7a. Provider Name	Percent missing of those Responding 3-7, or 9 to VIIB1 (Discharge Location)	Expected Responses	45	—	23	—	17	—	0	—	1	86	—
—	—	Total Responses	65	0	25	0	59	0	1	0	4	154	56
—	—	% missing	10	—	12	—	29	—	100	—	0	—	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
VIID7b. Provider Type	Percent missing of those Responding 3-7, or 9 to VIIB1 (Discharge Location)	Expected Responses	43	—	16	—	17	—	0	—	1	77	—
—	—	Total Responses	60	0	16	0	50	0	1	0	2	129	60
—	—	% missing	14	—	38	—	29	—	—	—	0	—	—
VIID7c_a--Enter Provider City	Percent missing of those Responding 3-7, or 9 to VIIB1 (Discharge Location)	Expected Responses	44	—	18	—	18	—	0	—	1	81	—
—	—	Total Responses	60	0	18	0	57	0	1	0	3	139	58
—	—	% missing	12	—	31	—	25	—	—	—	0	—	—
VIID7c_b--Enter Provider State	Percent missing of those Responding 3-7, or 9 to VIIB1 (Discharge Location	Expected Responses	40	—	20	—	20	—	0	—	1	81	—
—	—	Total Responses	54	0	20	0	55	0	1	0	2	132	61
—	—	% missing	20	—	23	—	17	—	—	—	0	—	—
VIID7d. Medicare Provider ID Number	Percent missing of those Responding 3-7, or 9 to VIIB1 (Discharge Location)	Expected Responses	0	—	0	—	0	—	0	—	0	0	—
—	—	Total Responses	2	0	0	0	0	0	1	0	0	3	0
—	—	% missing	100	—	—	—	—	—	—	—	—	—	—
E. Discharge Delay VIIE1. Was discharge delayed for at least 24 hrs.	Discharge Delayed at Least 24 hrs. Responding Yes	"Yes" Responses	20	—	—	—	11	—	—	—	1	32	—
—	—	Total Responses	94	0	25	0	93	0	1	0	8	221	—
—	—	% "Yes" Responses	21	—	—	—	12	—	—	—	13	14	—

(continued)

Table D-1 (continued)
Responses to skip-logic questions

Question	Skip Logic	Result	AH DISCH	LTCH ADM	LTCH DISCH	IRF ADM	IRF DISCH	SNF ADM	SNF DISCH	HHA ADM	HHA DISCH	Overall	% of responses expected to answer
VIIE2. Reason for Discharge Delay	Percent missing of those Responding Yes to VIIE1 (Discharge Delayed 24hrs)	Expected Responses	20	—	—	—	10	—	—	—	1	31	—
—	—	Total Responses	21	0	0	0	11	0	0	0	1	33	94
—	—	% missing	0	—		—	9	—	—	—	0	—	—

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APPENDIX E
FREQUENCY DISTRIBUTION OF RESPONSES TO MULTIPLE CHOICE AND SELECT ALL THAT APPLY QUESTIONS

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Table E-1a
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	I. Administrative Items								
	QIA8. Gender								
1	Male	249	45.4%	45	45%	59	50.0%	26	49.1%
2	Female	300	54.6%	56	55%	59	50.0%	27	50.9%
	QIA9. Ethnicity								
1	American Indian or Alaska Native	0	0%	—	—	—	—	—	—
2	Asian	4	0.7%	2	2%	1	0.9%	1	1.8%
3	Black or African American	78	14.3%	4	4%	32	27.6%	17	30.4%
4	Hispanic or Latino	23	4.2%	2	2%	7	6.0%	5	8.9%
5	Native Hawaiian or Pacific Islander	12	2.2%	2	2%	—	—	—	—
6	White	417	76.5%	88	88%	76	65.5%	31	55.4%
2, 6	White and Asian	2	0.4%	—	—	—	—	—	—
7	Unknown	7	1.3%	2	2%	—	—	—	—
	QIA10. Educational Level								
1	Less than 1 year of high school	68	17.7%	7	9%	17	48.6%	3	50.0%
2	High School Graduate or GED	144	37.5%	41	51%	10	28.6%	2	33.3%
3	Some college	101	26.3%	21	26%	6	17.1%	1	16.7%
4	Four-year college degree	43	11.2%	7	9%	—	—	—	—
5	More than 4 years of college	28	7.3%	4	5%	2	5.7%	—	—
	QIA11. Advanced Directive								
0	No	306	58.5%	24	25%	63	57.8%	41	91.1%
1	Yes	217	41.5%	73	75%	46	42.2%	4	8.9%
	QIA12. Durable Power of Attorney								
0	No	314	59.7%	39	39%	49	45.8%	32	68.1%
1	Yes	212	40.3%	61	61%	58	54.2%	15	31.9%
	QIA13. Code Status Documented								
0	No	239	44.8%	10	10%	28	23.9%	21	40.4%
1	Yes	295	55.2%	86	90%	89	76.1%	31	59.6%
B1a	Q1B1. Current Payment Source	0	0%	—	—	—	—	—	—
B1b	Medicare (traditional fee-for-service)	167	43.5%	28	28%	51	44.7%	—	—
B1c	Medicare (HMO/Managed Care)	3	0.8%	—	—	3	2.6%	—	—
B1d	Medicaid (traditional fee-for-service)	0	0%	—	—	—	—	—	—
B1d, B1b	Medicaid (traditional fee-for-service) AND Medicare (traditional fee-for-service)	38	9.9%	7	7%	21	18.4%	—	—
B1e	Medicaid (HMO/Managed care)	0	0%	—	—	—	—	—	—
B1e, B1b	Medicaid (HMO/Managed care) AND Medicare (traditional fee-for-service)	1	0.3%	1	1%	—	—	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
B1f	Workers' compensation	0	0%	—	—	—	—	—	—
B1g	Title programs (e.g., Title III, V, or XX)	0	0%	—	—	—	—	—	—
B1h	Other government (e.g., CHAMPUS, VA, etc.)	0	0%	—	—	—	—	—	—
B1i	Private insurance	1	0.3%	—	—	—	—	—	—
B1i, B1d	Private insurance AND Medicare (traditional fee-for-service)	119	31.0%	34	34%	22	19.3%	—	—
B1i, B1c	Private insurance AND Medicare (HMO/Managed care)	2	0.5%	2	2%	—	—	—	—
B1i, B1d	Private insurance AND Medicaid (traditional fee-for-service)	1	0.3%	1	1%	—	—	—	—
B1j, B1b	Private HMO/managed care AND Medicare (traditional fee-for-service)	3	0.8%	1	1%	2	1.8%	—	—
B1k, B1d, B1b	Self-pay AND Medicaid (traditional fee-for-service) AND Medicare (traditional fee-for-service)	2	0.5%	—	—	2	1.8%	—	—
B1l	Other	2	0.5%	2	2%	—	—	—	—
B1l, B1b	Other AND Medicare (traditional fee-for-service)	43	11.2%	22	22%	12	10.5%	—	—
B1l, B1c	Other AND Medicare (HMO/managed care)	1	0.3%	—	—	1	0.9%	—	—
B1l, B1d	Other AND Medicaid (traditional fee-for-service)	1	0.3%	1	1%	—	—	—	—
B1m	Unknown	0	0%	—	—	—	—	—	—
	II. Admission Information								
	QIIA2. Admitted From								
1	Private residence	103	29.6%	74	76%	2	2.4%	—	—
2	Community-based residence (e.g., assisted living residence, group home, adult foster care)	13	3.7%	11	11%	—	—	—	—
3	Long-term care facility/nursing home	6	1.7%	3	3%	3	3.7%	—	—
4	Skilled nursing facility (includes subacute) (SNF/TCU)	15	4.3%	7	7%	1	1.2%	—	—
5	Short-stay acute hospital. (IPPS)	206	59.2%	2	2%	75	91.5%	—	—
6	Long-term care hospital. (LTCH)	2	0.6%	1	1%	—	—	—	—
7	Inpatient rehabilitation hospital or unit	3	0.9%	—	—	1	1.2%	—	—
8	Psychiatric Hospital or unit	0	0%	—	—	—	—	—	—
9	Hospice	0	0%	—	—	—	—	—	—
10	Other	0	0%	—	—	—	—	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QIIA4. Prior Services								
A4a	Skilled nursing facility (includes subacute)	28	29.2%	7	41%	13	34.2%	—	—
A4b	Inpatient rehabilitation hospital or unit	6	6.3%	—	—	1	2.6%	—	—
A4c	Long-term care hospital	2	2.1%	—	—	2	5.3%	—	—
A4d	Psychiatric Hospital or unit	0	0%	—	—	—	—	—	—
A4a, A4b, A4c	Skilled nursing facility (includes subacute) AND inpatient rehabilitation hospital or unit AND and long-term care hospital	1	1.0%	—	—	1	2.6%	—	—
A4e	Acute short admission hospital	25	26.0%	1	6%	7	18.4%	—	—
A4a, A4e	Skilled nursing facility (includes subacute) AND acute short admission hospital	4	4.2%	—	—	—	—	—	—
A4a, A4b, A4c, A4e	Skilled nursing faciltiy (includes subacute) AND inpatient rehabilitation hospital or unit AND long-term care hospital AND acute short admission hospital	1	1.0%	—	—	1	2.6%	—	—
A4f	Home health	23	24.0%	9	53%	8	21.1%	—	—
A4a, A4f	Skilled nursing facility (includes subacute) AND Home health	1	1.0%	—	—	1	2.6%	—	—
A4b, A4f	Inpatient rehabilitation hospital or unit AND Home health	1	1.0%	—	—	—	—	—	—
A4e, A4f	Acute short admission hospital AND Home health	2	2.1%	—	—	2	5.3%	—	—
A4a, A4e, A4f	Skilled nursing facility (includes subacute) AND acute short admission hospital AND home health	2	2.1%	—	—	2	5.3%	—	—
	QIIA5. Prior Residence								
1	Private residence	277	82.0%	77	79%	53	67.9%	—	—
2	Community-based residence	26	7.7%	11	11%	1	1.3%	—	—
3	Permanently in a long-term care facility	32	9.5%	8	8%	23	29.5%	—	—
4	Other	3	0.9%	1	1%	1	1.3%	—	—
	QIIA7. Lives with								
A7a	Lives Alone	100	33.2%	29	35%	18	32.1%	—	—
A7b	Spouse or Significant other	115	38.2%	32	39%	21	37.5%	—	—
A7c	Adult child (> 18 years)	43	14.3%	10	12%	9	16.1%	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
A7b, A7c	Spouse or Significant other AND Adult child (> 18 years)	10	3.3%	5	6%	—	—	—	—
A7d	Other unpaid family member or friend	16	5.3%	2	2%	3	5.4%	—	—
A7c, A7d	Adult child (> 18 years) AND Other unpaid family member or friend	2	0.7%	1	1%	—	—	—	—
A7e	Paid help living in the home (other than home care)	12	4.0%	4	5%	3	5.4%	—	—
A7b, A7e	Spouse or Significant other AND Paid help living in the home (other than home care)	2	0.7%	—	—	1	1.8%	—	—
A7d, A7e	Other unpaid family member or friend AND Paid help living in the home (other than home care)	1	0.3%	—	—	1	1.8%	—	—
	QIIA8A. Prior Function Self Care								
3	Independent	196	58.3%	61	64%	32	40.0%	—	—
2	Needed Some Help	92	27.4%	22	23%	22	27.5%	—	—
1	Dependent	44	13.1%	12	13%	23	28.8%	—	—
9	Not applicable	4	1.2%	1	1%	3	3.8%	—	—
	QIIA8B. Prior Function Mobility								
3	Independent	199	59.4%	66	69%	30	38.0%	—	—
2	Needed Some Help	84	25.1%	20	21%	24	30.4%	—	—
1	Dependent	45	13.4%	8	8%	22	27.8%	—	—
9	Not applicable	7	2.1%	1	1%	3	3.8%	—	—
	QIIA8C. Prior Function Cognition								
3	Independent	189	56.8%	59	63%	30	38.5%	—	—
2	Needed Some Help	80	24.0%	21	23%	20	25.6%	—	—
1	Dependent	49	14.7%	8	9%	25	32.1%	—	—
9	Not applicable	15	4.5%	5	5%	3	3.8%	—	—
	QIIA9. Change in mental status								
0	No	246	73.7%	71	76%	55	68.8%	—	—
1	Yes	61	18.3%	15	16%	12	15.0%	—	—
9	Unknown	27	8.1%	8	9%	13	16.3%	—	—
	QIIA10. History of Incontinence								
0	No	198	57.9%	61	64%	29	35.8%	—	—
1	Bladder only	31	9.1%	6	6%	1	1.2%	—	—
2	Bowel only	8	2.3%	2	2%	4	4.9%	—	—
3	Bladder and bowel	51	14.9%	10	11%	19	23.5%	—	—
9	Unknown	54	15.8%	16	17%	28	34.6%	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	III. Current Medical Items								
	QIIIC1. Diagnostic Procedures during Admission?								
0	No	61	29.9%	12	14%	1	100.0%	15	46.9%
1	Yes	142	69.6%	72	86%	—	—	16	50.0%
	QIIID1. None								
1	At Discharge	248	91.2%	14	58%	11	100.0%	11	100.0%
2	Anytime during stay	24	8.8%	10	42%	—	—	—	—
	QIIID2. Insulin Drip								
1	At Discharge	0	0.0%	—	—	—	—	—	—
2	Anytime during stay	4	100.0%	3	100%	—	—	—	—
	QIIID3. Total Parenteral Nutrition								
1	At Discharge	4	66.7%	—	—	2	100.0%	1	33.3%
2	Anytime during stay	2	33.3%	—	—	—	—	2	66.7%
	QIIID4. Central Line Management								
1	At Discharge	80	74.8%	4	25%	51	100.0%	17	63.0%
2	Anytime during stay	27	25.2%	12	75%	—	—	10	37.0%
	QIIID5. Blood Transfusion(s)								
1	At Discharge	4	17.4%	—	—	2	100.0%	2	50.0%
2	Anytime during stay	19	82.6%	17	100%	—	—	2	50.0%
	QIIID6. Controlled Parenteral Analgesia - Peripheral								
1	At Discharge	6	22.2%	—	—	4	100.0%	2	100.0%
2	Anytime during stay	21	77.8%	20	100%	—	—	—	—
	QIIID7. Controlled Parenteral Analgesia - Epidural								
1	At Discharge	1	20.0%	—	—	—	—	1	100.0%
2	Anytime during stay	4	80.0%	4	100%	—	—	—	—
	QIIID8. Left Ventricular Assistive Device (LVAD)								
1	At Discharge	1	50.0%	—	—	—	—	—	—
2	Anytime during stay	1	50.0%	1	100%	—	—	—	—
	QIIID9. Continuous Cardiac Monitoring								
1	At Discharge	6	12.5%	—	—	2	100.0%	4	80.0%
2	Anytime during stay	42	87.5%	41	100%			1	20.0%
	QIIID10. Chest Tube(s)								
1	At Discharge	2	28.6%	—	—	2	100.0%	—	—
2	Anytime during stay	5	71.4%	5	100%	—	—	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QIIID11. ET Tube Care and Management								
1	At Discharge	2	40.0%	—	—	—	—	2	100.0%
2	Anytime during stay	3	60.0%	3	100%	—	—	—	—
	QIIID12. Trach Tube with Suctioning:								
1	At Discharge	70	82.4%	—	—	56	100.0%	12	46.2%
2	Anytime during stay	15	17.6%	1	100%	—	—	14	53.8%
	QIIID13. High O2 Concentration Delivery System with Fi)2 > 40%								
1	At Discharge	8	44.4%	—	—	2	100.0%	6	66.7%
2	Anytime during stay	10	55.6%	7	100%	—	—	3	33.3%
	QIIID14. Ventilator - Weaning								
1	At Discharge	55	76.4%	—	—	48	100.0%	7	33.3%
2	Anytime during stay	17	23.6%	3	100%	—	—	14	66.7%
	QIIID15. ventilator - Non-Weaning								
1	At Discharge	9	90.0%	—	—	2	100.0%	7	87.5%
2	Anytime during stay	1	10.0%	—	—	—	—	1	12.5%
	QIIID16. Hemodialysis								
1	At Discharge	29	93.5%	1	100%	13	100.0%	8	80.0%
2	Anytime during stay	2	6.5%	—	—	—	—	2	20.0%
	QIIID18. Peritoneal Dialysis								
1	At Discharge	12	85.7%	—	—	4	100.0%	6	85.7%
2	Anytime during stay	2	14.3%	1	100%	—	—	1	14.3%
	QIIID19. Fistula or Other Drain Management								
1	At Discharge	12	85.7%	—	—	8	100.0%	3	60.0%
2	Anytime during stay	2	14.3%	—	—	—	—	2	40.0%
	QIIID20. Negative Pressure Wound Therapy								
1	At Discharge	19	73.1%	2	50%	12	100.0%	5	50.0%
2	Anytime during stay	7	26.9%	2	50%	—	—	5	50.0%
	QIIID23. One-on-one 24-Hour Supervision								
1	At Discharge	0	0%	—	—	—	—	—	—
2	Anytime during stay	7	26.9%	2	100%	—	—	5	50.0%
	QIIID24. Specialty Bed								
1	At Discharge	79	80.6%	1	20%	54	100.0%	12	46.2%
2	Anytime during stay	19	19.4%	4	80%	—	—	14	53.8%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QIIIF1. Allergy Status								
0	No known	115	54.5%	33	44%	—	—	31	62.0%
1	Yes	96	45.5%	42	56%	—	—	19	38.0%
	QIIIG1A. Pressure Ulcer Risk Assessment								
0	No	50	9.5%	3	3%	3	3.1%	3	5.1%
1	Yes, it indicated not high risk	342	64.8%	80	83%	34	35.1%	27	45.8%
2	Yes, it indicated high risk	136	25.8%	13	14%	60	61.9%	29	49.2%
	QIIIG1B. Presence of Pressure Ulcer								
0	No	414	79.8%	90	97%	56	56.6%	33	57.9%
1	Yes	105	20.2%	3	3%	43	43.4%	24	42.1%
	QIIIG2A. Unhealed Pressure Ulcer Stg2								
0	No unhealed ulcers at this stage	117	65.4%	2	40%	41	61.2%	31	75.6%
1	One unhealed ulcer at this stage	41	22.9%	—	—	16	23.9%	5	12.2%
2	Two unhealed ulcers at this stage	15	8.4%	3	60%	6	9.0%	4	9.8%
3	Three unhealed ulcers at this stage	5	2.8%	—	—	3	4.5%	1	2.4%
4	Four or more unhealed ulcers at this stage	1	0.6%	—	—	1	1.5%	—	—
	QIIIG2B. Stg2 Pressure Ulcers found this admission								
0	No unhealed ulcers at this stage	47	78.3%	—	—	—	—	30	78.9%
1	One unhealed ulcer at this stage	11	18.3%	4	100%	—	—	6	15.8%
2	Two unhealed ulcers at this stage	2	3.3%	—	—	—	—	2	5.3%
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2C. Unhealed Pressure Ulcers Stg3								
0	No unhealed ulcers at this stage	122	77.2%	2	100%	47	72.3%	24	64.9%
1	One unhealed ulcer at this stage	25	15.8%	—	—	12	18.5%	9	24.3%
2	Two unhealed ulcers at this stage	2	1.3%	—	—	1	1.5%		
3	Three unhealed ulcers at this stage	4	2.5%	—	—	2	3.1%	2	5.4%
4	Four or more unhealed ulcers at this stage	5	3.2%	—	—	3	4.6%	2	5.4%
	QIIIG2D. Stg3 Pressure Ulcers found this admission								
0	No unhealed ulcers at this stage	41	89.1%	3	100%	—	—	30	90.9%
1	One unhealed ulcer at this stage	3	6.5%	—	—	—	—	2	6.1%
2	Two unhealed ulcers at this stage	2	4.3%	—	—	—	—	1	3.0%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2E. Unhealed Pressure Ulcers Stg4								
0	No unhealed ulcers at this stage	126	79.7%	2	100%	53	77.9%	26	68.4%
1	One unhealed ulcer at this stage	25	15.8%	—	—	12	17.6%	8	21.1%
2	Two unhealed ulcers at this stage	7	4.4%	—	—	3	4.4%	4	10.5%
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2F. Stg4 Pressure Ulcers found this admission								
0	No unhealed ulcers at this stage	45	95.7%	3	100%	—	—	33	94.3%
1	One unhealed ulcer at this stage	2	4.3%	—	—	—	—	2	5.7%
2	Two unhealed ulcers at this stage	0	0%	—	—	—	—	—	—
3	Three unhealed ulcers at this stage	0	0%	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	0	0%	—	—	—	—	—	—
	QIIIG2G. Unhealed Pressure Ulcers unstageable								
0	No unhealed ulcers at this stage	127	79.4%	2	67%	49	72.1%	30	83.3%
1	One unhealed ulcer at this stage	20	12.5%	—	—	12	17.6%	2	5.6%
2	Two unhealed ulcers at this stage	8	5.0%	1	33%	3	4.4%	3	8.3%
3	Three unhealed ulcers at this stage	2	1.3%	—	—	2	2.9%	—	—
4	Four or more unhealed ulcers at this stage	3	1.9%	—	—	2	2.9%	1	2.8%
	QIIIG2H. Unstageable Pressure Ulcers found this admission								
0	No unhealed ulcers at this stage	44	95.7%	3	100%	—	—	32	94.1%
1	One unhealed ulcer at this stage	1	2.2%	—	—	—	—	1	2.9%
2	Two unhealed ulcers at this stage	—	—	—	—	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	1	2.2%	—	—	—	—	1	2.9%
	QIIIG5. Ulcers with Tunneling								
0	No	124	79.5%	2	100%	48	71.6%	30	81.1%
1	Yes	23	14.7%	—	—	15	22.4%	4	10.8%
9	Unable to assess	9	5.8%	—	—	4	6.0%	3	8.1%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QIIIG6. Major wound present								
0	No	295	79.3%	47	72%	59	70.2%	35	70.0%
1	Yes	77	20.7%	18	28%	25	29.8%	15	30.0%
	QIIIG8. Turning Surfaces								
	None - Skin for all turning surfaces are								
G8a	intact	113	57.9%	14	88%	16	34.0%	12	42.9%
G8b	Right Hip	11	5.6%	1	6%	4	8.5%	1	3.6%
G8c	Left Hip	11	5.6%	—	—	—	—		
G8b, G8c	Right Hip AND Left Hip	3	1.5%	—	—	1	2.1%	1	3.6%
G8d	Back/Buttocks	49	25.1%	1	6%	21	44.7%	12	42.9%
G8b, G8d	Right Hip AND Back/Buttocks	4	2.1%	—	—	3	6.4%	1	3.6%
G8c, G8d	Left Hip AND Back/Buttocks	2	1.0%	—	—	1	2.1%	—	—
G8b, G8c, G8d	Right Hip AND Left Hip AND Back/Buttocks	2	1.0%	—	—	1	2.1%	1	3.6%
	IV. Cognitive Status								
	QIVA1. Patient Comatose								
0	No	489	95.7%	86	93%	86	93.5%	53	94.6%
1	Yes	22	4.3%	6	7%	6	6.5%	3	5.4%
	QIVB1. BIMS Attempted								
0	No	125	24.6%	9	10%	37	38.5%	33	62.3%
1	Yes	384	75.4%	85	90%	59	61.5%	20	37.7%
	QIVB1A. Reason for no BiMS								
1	unresponsive	18	14.8%	2	22%	9	24.3%	5	21.7%
2	communication disorder	28	23.0%	2	22%	19	51.4%	5	21.7%
3	no interpreter available	15	12.3%	3	33%	—	—	1	4.3%
4	other	61	50.0%	2	22%	9	24.3%	12	52.2%
	QIVB2. Repetition of Three Words								
—	None	19	4.9%	4	5%	3	5.5%	2	10.0%
—	One	6	1.5%	2	2%	3	5.5%	1	5.0%
—	Two	19	4.9%	4	5%	7	12.7%	1	5.0%
—	Three	346	88.5%	77	89%	42	76.4%	15	75.0%
—	***out of range***	1	0.3%	—	—	—	—	1	5.0%
	QIVB3A. Current Year?								
	Missed by more than 5 years or no								
—	answer	36	9.3%	6	7%	10	17.9%	6	30.0%
—	Missed by 2 to 5 years	5	1.3%	3	3%	2	3.6%	—	—
—	Missed by 1 year	12	3.1%	1	1%	4	7.1%	3	15.0%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
—	Correct	334	86.1%	78	89%	40	71.4%	10	50.0%
—	***out of range***	1	0.3%	—	—	—	—	1	5.0%
	QIVB3B. Current Month								
—	Missed by more than 1 month	50	12.9%	9	10%	21	37.5%	5	25.0%
—	Missed by 6 days to 1 month	40	10.3%	8	9%	4	7.1%	6	30.0%
—	Accurate within 5 days	296	76.3%	71	81%	31	55.4%	7	35.0%
—	—	1	0.3%	—	—	—	—	1	5.0%
—	—	1	0.3%	—	—	—	—	1	5.0%
	QIVB4. Recalls Sock								
—	No, could not recall	68	17.5%	19	22%	9	16.4%	6	30.0%
—	Yes, after cueing ("something to wear")	57	14.7%	12	14%	13	23.6%	3	15.0%
—	Yes, no cue required	262	67.5%	55	64%	33	60.0%	10	50.0%
—	—	1	0.3%	—	—	—	—	1	5.0%
	QIVB5. Recalls Blue								
—	No, could not recall	45	11.5%	9	10%	9	16.4%	6	30.0%
—	Yes, after cueing ("a color")	64	16.4%	16	18%	11	20.0%	3	15.0%
—	Yes, no cue required	280	71.8%	62	71%	35	63.6%	10	50.0%
—	—	1	0.3%	—	—	—	—	1	5.0%
	QIVB6. Recalls Bed								
—	No, could not recall	87	22.3%	27	31%	11	20.0%	5	25.0%
—	Yes, after cueing ("a piece of furniture")	66	16.9%	16	18%	13	23.6%	3	15.0%
—	Yes, no cue required	236	60.5%	45	51%	31	56.4%	11	55.0%
—	—	1	0.3%	—	—	—	—	1	5.0%
	QIVC1. Short Term Memory								
—	Memory OK	146	65.2%	23	82%	30	73.2%	7	23.3%
—	Memory problem	54	24.1%	5	18%	8	19.5%	2	6.7%
—	Unable to assess	24	10.7%	—	—	3	7.3%	21	70.0%
	QIVC2. Long Term Memory								
—	Memory OK	153	69.2%	23	82%	32	78.0%	7	23.3%
—	Memory problem	44	19.9%	5	18%	6	14.6%	2	6.7%
—	Unable to assess	24	10.9%	—	—	3	7.3%	21	70.0%
	QIVC3. Memory Recall Ability								
C3a	Current season	7	2.8%	1	3%	—	—	—	—
C3b	Location of own room	—	—	—	—	—	—	—	—
C3a, C3b	Current season AND Location of own room	8	3.1%	—	—	1	1.6%	—	—
C3c	Staff names and faces	—	—	—	—	—	—	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
C3a, C3c	Current season AND Staff names and faces	2	0.8%	—	—	—	—	—	—
C3a, C3b, C3c	Current season AND Location of own room AND Staff names and faces	6	2.4%	—	—	—	—	—	—
C3d	That he or she is in a hospital (or nursing home or home)	25	9.8%	5	16%	9	14.5%	1	3.3%
C3a, C3d	Current season AND That he or she is in a hospital (or nursing home or home)	27	10.6%	3	10%	16	25.8%	3	10.0%
C3a, C3b, C3d	Current season AND Location of own room AND That he or she is in a hospital (or nursing home or home)	17	6.7%	5	16%	5	8.1%	3	10.0%
C3c, C3d	Staff names and faces AND That he or she is in a hospital (or nursing home or home)	2	0.8%	—	—	—	—	—	—
C3a, C3c, C3d	Current season AND Staff names and faces AND That he or she is in a hospital (or nursing home or home)	12	4.7%	—	—	1	1.6%	—	—
C3b, C3c, C3d	Location of own room AND Staff names and faces AND That he or she is in a hospital (or nursing home or homes)	3	1.2%	1	3%	—	—	1	3.3%
C3a, C3b, C3c, C3d	Current season AND Location of own room AND Staff names and faces AND That he or she is in a hospital (or nursing home or home)	67	26.4%	11	35%	7	11.3%	3	10.0%
C3e	None of the above are recalled or unable to assess	74	29.1%	5	16%	22	35.5%	19	63.3%
C3a, C3b, C3e	Current season AND Location of own room AND None of the above are recalled or unable to assess	1	0.4%	—	—	—	—	—	—
C3a, C3b, C3c, C3d, C3e	Current season AND Location of own room AND Staff names and faces AND That he or she is in a hospital (or nursing home or home) AND None of the above are recalled or unable to assess	3	1.2%	—	—	1	1.6%	—	—
0	QIVC4. Daily Decisionmaking Independent: decisions consistently reasonable	101	42.4%	14	52%	18	29.5%	7	21.9%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
1	Impaired: some difficulty or decisions poor; supervision required	68	28.6%	10	37%	11	18.0%	4	12.5%
9	Unable to assess	68	28.6%	3	11%	32	52.5%	20	62.5%
—	***out of range***	1	0.4%	—	—	—	—	1	3.1%
	QIVD1. Inattention								
0	Behavior is not present	344	70.9%	69	78%	58	61.1%	18	42.9%
1	Behavior continuously present, does not fluctuate.	47	9.7%	6	7%	13	13.7%	4	9.5%
2	Behavior present, fluctuates (comes and goes, changes in severity)	80	16.5%	14	16%	24	25.3%	6	14.3%
—	***out of range***	—	—	—	—	—	—	14	33.3%
	QIVD2. Disorganized Thinking								
0	Behavior is not present	365	75.3%	70	79%	65	69.1%	21	50.0%
1	Behavior continuously present, does not fluctuate.	38	7.8%	5	6%	10	10.6%	2	4.8%
2	Behavior present, fluctuates (comes and goes, changes in severity)	68	14.0%	14	16%	19	20.2%	5	11.9%
—	***out of range***	14	2.9%	—	—	—	—	14	33.3%
	QIVD3. Level of Alertness								
0	Behavior is not present	390	78.5%	73	81%	59	59.6%	23	50.0%
1	Behavior continuously present, does not fluctuate.	31	6.2%	3	3%	16	16.2%	6	13.0%
2	Behavior present, fluctuates (comes and goes, changes in severity)	62	12.5%	14	16%	24	24.2%	3	6.5%
—	***out of range***	14	2.8%	—	—	—	—	14	30.4%
	QIVD4. Psychomotor Retardation								
0	Behavior is not present	381	79.7%	76	86%	53	61.6%	22	51.2%
1	Behavior continuously present, does not fluctuate.	27	5.6%	5	6%	9	10.5%	4	9.3%
2	Behavior present, fluctuates (comes and goes, changes in severity)	56	11.7%	7	8%	24	27.9%	3	7.0%
—	—	14	2.9%	—	—	—	—	14	32.6%
	QIVE1. Aggressive to Others								
0	No	499	98.4%	90	98%	95	97.9%	45	91.8%
1	Yes	5	1.0%	2	2%	2	2.1%	1	2.0%
—	***out of range***	3	0.6%	—	—	—	—	3	6.1%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QIVE2. Verbally Abusive to Others								
0	No	493	96.9%	88	95%	95	99.0%	45	90.0%
1	Yes	13	2.6%	5	5%	1	1.0%	2	4.0%
—	***out of range***	3	0.6%	—	—	—	—	3	6.0%
	QIVE3. Disruptive Behavior								
0	No	487	96.6%	89	97%	89	91.8%	46	92.0%
1	Yes	14	2.8%	3	3%	8	8.2%	1	2.0%
—	***out of range***	3	0.6%	—	—	—	—	3	6.0%
	QIVF1. Mood Interview Attempted								
0	No	158	31.4%	8	9%	49	50.0%	29	58.0%
1	Yes	343	68.2%	83	91%	49	50.0%	19	38.0%
—	***out of range***	2	0.4%	—	—	—	—	2	4.0%
	QIVF2A. No Pleasure								
0	No	244	62.2%	55	61%	29	46.8%	13	46.4%
1	Yes	105	26.8%	26	29%	17	27.4%	7	25.0%
9	Unable to respond	43	11.0%	9	10%	16	25.8%	8	28.6%
	QIVF2B. Days no interest								
0	not at all (0 to 1 days)	43	25.6%	7	23%	9	36.0%	1	10.0%
1	several days (2 to 6 days)	60	45.1%	9	29%	13	52.0%	3	30.0%
2	more than half of the days (7 to 11 days)	15	11.3%	4	13%	1	4.0%	2	20.0%
3	nearly every day (12 to 14 days)	22	16.5%	11	35%	2	8.0%	2	20.0%
—	***out of range***	2	1.5%	—	—	—	—	2	20.0%
	QIVF2C. Hopelessness								
0	No	202	52.2%	51	59%	21	33.3%	8	26.7%
1	Yes	147	38.0%	31	36%	27	42.9%	11	36.7%
9	Unable to respond	38	9.8%	5	6%	15	23.8%	11	36.7%
	QIVF2D. Days Hopeless								
0	not at all (0 to 1 days)	33	18.3%	5	14%	11	29.7%	2	12.5%
1	several days (2 to 6 days)	98	54.4%	17	49%	16	43.2%	8	50.0%
2	more than half of the days (7 to 11 days)	24	13.3%	8	23%	4	10.8%	1	6.3%
3	nearly every day (12 to 14 days)	21	11.7%	5	14%	5	13.5%	2	12.5%
—	***out of range***	4	2.2%	—	—	1	2.7%	3	18.8%
	QIVF3. Feeling Sad								
0	Never	138	35.3%	38	43%	9	14.3%	—	—
1	Rarely	71	18.2%	15	17%	10	15.9%	7	26.9%
2	Sometimes	103	26.3%	19	22%	20	31.7%	7	26.9%
3	Often	25	6.4%	6	7%	5	7.9%	1	3.8%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
4	Always	13	3.3%	3	3%	3	4.8%	2	7.7%
9	Unable to respond	41	10.5%	7	8%	16	25.4%	9	34.6%
	QIVG1. Fatigue Interview Attempted								
0	No	223	45.1%	14	15%	57	57.6%	25	58.1%
1	Yes	269	54.5%	81	85%	42	42.4%	16	37.2%
—	***out of range***	2	0.4%	—	—	—	—	2	4.7%
	QIVG2. Fatigue								
0	Never	103	33.2%	30	35%	13	25.0%	3	12.0%
1	Rarely	56	18.1%	21	24%	4	7.7%	1	4.0%
2	Sometimes	60	19.4%	12	14%	12	23.1%	7	28.0%
3	Often	38	12.3%	11	13%	6	11.5%	3	12.0%
4	Always	16	5.2%	6	7%	3	5.8%	2	8.0%
9	Unable to respond	37	11.9%	6	7%	14	26.9%	9	36.0%
	QIVH1. Pain Interview Attempted								
0	No	98	19.1%	17	18%	21	21.9%	26	52.0%
1	Yes	413	80.5%	78	82%	75	78.1%	22	44.0%
—	***out of range***	2	0.4%	—	—	—	—	2	4.0%
	QIVH2. Pain Presence								
0	No	150	33.8%	17	21%	44	50.6%	9	31.0%
1	Yes	270	60.8%	64	79%	27	31.0%	14	48.3%
9	Unable to respond	24	5.4%	—	—	16	18.4%	6	20.7%
	QIVH3. Pain Severity VAS								
—	No pain	15	4.8%	6	9%	—	—	—	—
1	1	3	1.0%	—	—	—	—	1	5.3%
—	2	16	5.1%	3	4%	4	8.2%	1	5.3%
—	3	24	7.7%	5	7%	4	8.2%	2	10.5%
—	4	24	7.7%	4	6%	1	2.0%	1	5.3%
—	5	52	16.7%	13	19%	6	12.2%	—	—
—	6	28	9.0%	4	6%	2	4.1%	3	15.8%
—	7	8	6.7%	4	6%	4	8.2%	—	—
—	8	34	10.9%	8	12%	6	12.2%	2	10.5%
—	9	17	5.4%	4	6%	2	4.1%	—	—
—	Worst pain you can imagine	34	10.9%	14	21%	1	2.0%	3	15.8%
—	***out of range***	1	0.3%	—	—	—	—	—	—
—	patient does not answer or is unable to respond	43	13.8%	2	3%	19	38.8%	6	31.6%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QIVH4. Pain Severity Likert								
1	Mild	67	22.0%	14	22%	15	30.0%	3	14.3%
2	Moderate	116	38.0%	20	31%	10	20.0%	8	38.1%
3	Severe	64	21.0%	18	28%	6	12.0%	4	19.0%
4	Very severe, horrible	26	8.5%	11	17%	1	2.0%	1	4.8%
9	Unable to answer or no response	32	10.5%	2	3%	18	36.0%	5	23.8%
	QIVH5A. Pain Hard to Sleep								
0	No	183	59.6%	40	60%	19	38.0%	10	47.6%
1	Yes	98	31.9%	25	37%	16	32.0%	6	28.6%
9	Unable to answer or no response	26	8.5%	2	3%	15	30.0%	5	23.8%
	QIVH5B. Pain Limits Activity								
0	No	146	48.3%	24	36%	18	36.0%	6	30.0%
1	Yes	125	41.4%	40	61%	14	28.0%	9	45.0%
9	Unable to answer or no response	31	10.3%	2	3%	18	36.0%	5	25.0%
	QIVH6. Pain Observational Assessment								
G6a	Non-verbal sounds	3	2.1%	1	6%	2	4.4%	—	—
G6b	Vocal complaints of pain	13	8.9%	1	6%	—	—	1	5.9%
G6c	Facial Expressions	11	7.5%	2	12%	6	13.3%	—	—
G6a, G6c	Non-verbal sounds AND Facial Expressions	1	0.7%	—	—	1	2.2%	—	—
G6b, G6c	Vocal complaints of pain AND Facial Expressions	6	4.1%	1	6%	1	2.2%	—	—
G6a, G6b, G6c	Non-verbal sounds AND Vocal complaints of pain AND Facial expressions	1	0.7%	—	—	—	—	1	5.9%
G6d	Protective body movements or postures	6	4.1%	1	6%	1	2.2%	—	—
G6a, G6d	Non-verbal sounds AND Protective body movements or postures	1	0.7%	1	6%	—	—	—	—
G6a, G6b, G6d	Non-verbal sounds AND Vocal complaints of pain AND Protective body movements or postures	1	0.7%	—	—	—	—	—	—
G6d, G6c	Protective body movements or postures AND Facial expressions	7	4.8%	1	6%	—	—	—	—
G6a, G6c, G6d	Non-verbal sounds AND Facial Expressions AND Protective body movements or postures	4	2.7%	—	—	2	4.4%	1	5.9%
G6b, G6c, G6d	Vocal complaints of pain AND Facial Expressions AND Protective body movements or postures	3	2.1%	—	—	—	—	1	5.9%

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Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
G6a, G6b, G6c, G6d, G6e	Non-verbal sounds AND Vocal complaints of pain AND Facial Expressions AND Protective body movements or postures AND None	1	0.7%	1	6%	—	—	—	—
G6e	None	88	60.3%	8	47%	32	71.1%	13	76.5%
	V. Impairments								
	QVA1A. Bladder Incontinence								
0	No	346	65.8%	82	86%	18	18.6%	16	26.7%
1	Yes	180	34.2%	13	14%	79	81.4%	44	73.3%
	QVA1B. Bowel Incontinence								
0	No	440	88.9%	95	100%	49	60.5%	32	66.7%
1	Yes	55	11.1%	—	—	32	39.5%	16	33.3%
	QVA2A. Bladder Incontinence Frequency								
0	Continent	278	61.4%	65	76%	11	15.9%	11	28.2%
1	Incontinent less than daily	37	8.2%	8	9%	4	5.8%	5	12.8%
2	Incontinent daily	42	9.3%	6	7%	2	2.9%	4	10.3%
3	Always incontinent	82	18.1%	7	8%	44	63.8%	13	33.3%
4	No urine/bowel output during the last 2 days	14	3.1%	—	—	8	11.6%	6	15.4%
	QVA2B. Bowel Incontinence Frequency								
0	Continent	319	63.5%	73	80%	16	19.3%	10	18.9%
1	Incontinent less than daily	41	8.2%	7	8%	6	7.2%	6	11.3%
2	Incontinent daily	47	9.4%	4	4%	10	12.0%	15	28.3%
3	Always incontinent	88	17.5%	5	5%	49	59.0%	21	39.6%
4	No urine/bowel output during the last 2 days	7	1.4%	2	2%	2	2.4%	1	1.9%
	QVA3A. Bladder								
0	No	225	43.8%	50	57%	10	10.8%	8	12.9%
1	Yes	289	56.2%	38	43%	83	89.2%	54	87.1%
	QVA3B. Bowel								
0	No	262	52.7%	56	64%	12	13.6%	7	13.5%
1	Yes	235	47.3%	31	36%	76	86.4%	45	86.5%
	QVB1. Swallowing Disorder Signs								
B1a	No sign or symptom of a possible swallowing disorder	350	73.4%	83	87%	27	39.1%	21	55.3%
B1b	Complaints of difficulty or pain with swallowing	20	4.2%	4	4%	1	1.4%	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
B1c	Coughing or choking during meals or when swallowing medications	39	8.2%	6	6%	1	1.4%	5	13.2%
—	—	1	0.2%	—	—	1	1.4%	—	—
B1d	Holding food in mouth/cheeks or residual food in mouth after meals	12	2.5%	—	—	2	2.9%	—	—
B1e	Loss of liquids/solids from mouth when eating or drinking	6	1.3%	2	2%	1	1.4%	—	—
B1f	***out of range***	48	10.1%	—	—	36	52.2%	11	28.9%
	QVB2. Usual ability to swallow								
1	Tube/parenteral feedings	104	20.0%	1	1%	65	66.3%	30	55.6%
2	Modified food consistency/supervision	91	17.5%	9	9%	17	17.3%	12	22.2%
3	Regular food	324	62.4%	85	89%	16	16.3%	12	22.2%
	QVC1. Comprehension								
1	Rarely/never understands	13	2.6%	3	3%	2	2.4%	3	5.7%
2	Usually/sometimes understands	114	22.8%	14	15%	19	23.2%	10	18.9%
3	Understands	332	66.4%	74	78%	46	56.1%	18	34.0%
9	Unable to assess	41	8.2%	4	4%	15	18.3%	22	41.5%
	QVC2. Expression								
1	Rarely/Never expresses self or speech is very difficult to understand	13	2.6%	2	2%	7	8.4%	—	—
2	Exhibits difficulty with expressing needs and ideas or speech is not clear	106	21.1%	9	9%	18	21.7%	7	13.2%
3	Expresses complex messages without difficulty and with speech that is clear and easy to understand	333	66.2%	79	83%	40	48.2%	19	35.8%
9	Unable to assess	51	10.1%	5	5%	18	21.7%	27	50.9%
	QVC3. Vision								
1	Severely Impaired	9	1.8%	1	1%	3	3.6%	1	1.9%
2	Mildly to Moderately Impaired	86	17.1%	15	16%	15	17.9%	4	7.7%
3	Adequate	353	70.2%	74	77%	47	56.0%	22	42.3%
9	Unable to assess	55	10.9%	6	6%	19	22.6%	25	48.1%
	QVC4. Hearing								
1	Severely Impaired	6	1.2%	2	2%	—	—	—	—
2	Mildly to Moderately Impaired	85	16.8%	20	21%	16	19.0%	4	7.7%
3	Adequate	369	73.1%	70	73%	54	64.3%	24	46.2%
9	Unable to assess	45	8.9%	4	4%	14	16.7%	24	46.2%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QVD1A. L Shoulder ROM								
0	Limited Range of Motion	113	21.6%	20	21%	34	36.6%	14	24.1%
1	Within Normal Limits	409	78.4%	76	79%	59	63.4%	44	75.9%
	QVD1B. L Elbow ROM								
0	Limited Range of Motion	83	15.9%	11	11%	33	35.5%	14	23.7%
1	Within Normal Limits	439	84.1%	86	89%	60	64.5%	45	76.3%
	QVD1C. R Shoulder ROM								
0	Limited Range of Motion	106	20.2%	19	20%	35	38.0%	13	22.0%
1	Within Normal Limits	418	79.8%	78	80%	57	62.0%	46	78.0%
	QVD1D. R Elbow ROM								
0	Limited Range of Motion	75	14.4%	8	8%	32	34.4%	13	22.0%
1	Within Normal Limits	445	85.6%	88	92%	61	65.6%	46	78.0%
	QVE1A. L UE Weightbearing								
0	Not fully weight-bearing	406	79.1%	92	97%	32	35.2%	24	40.7%
1	Fully weight-bearing:	107	20.9%	3	3%	59	64.8%	35	59.3%
	QVE1B. R UE Weightbearing								
0	Not fully weight-bearing	414	79.6%	94	98%	33	35.9%	27	45.8%
1	Fully weight-bearing:	106	20.4%	2	2%	59	64.1%	32	54.2%
	QVE1C. L LE Weightbearing								
0	Not fully weight-bearing	377	72.2%	90	94%	23	25.0%	15	25.0%
1	Fully weight-bearing:	145	27.8%	6	6%	69	75.0%	45	75.0%
	QVE1D. R LE Weightbearing								
0	Not fully weight-bearing	379	72.6%	93	97%	24	26.1%	17	28.3%
1	Fully weight-bearing:	143	27.4%	3	3%	68	73.9%	43	71.7%
	QVE1E. Buttocks								
0	Not fully weight-bearing	396	76.7%	91	96%	23	25.6%	19	31.7%
1	Fully weight-bearing:	120	23.3%	4	4%	67	74.4%	41	68.3%
	QVF1. Shortness of Breath								
0	Never, patient was not short of breath	260	53.8%	57	60%	2	2.8%	7	18.4%
1	When climbing stairs	10	2.1%	—	—	—	—	1	2.6%
2	With moderate exertion	53	11.0%	12	13%	2	2.8%	1	2.6%
3	With minimal exertion	39	8.1%	13	14%	—	—	4	10.5%
4	At rest	8	1.7%	3	3%	—	—	1	2.6%
9	Not assessed	113	23.4%	10	11%	68	94.4%	24	63.2%
	QVG1. Stop to rest when walking								
0	No	182	34.4%	29	30%	3	3.1%	5	8.1%
1	Yes	114	21.6%	36	37%	3	3.1%	2	3.2%
9	Not assessed	233	44.0%	32	33%	90	93.8%	55	88.7%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	VI. Functional Status								
	QVIA1. Toilet Hygiene								
0	Not attempted, not finished, or not applicable	13	2.9%	4	4%	1	2.3%	3	6.1%
1	Dependent	105	23.0%	16	17%	22	51.2%	19	38.8%
2	Substantial/Maximal Assistance	49	10.7%	9	9%	6	14.0%	4	8.2%
3	Partial/Moderate Assistance	65	14.3%	15	16%	5	11.6%	9	18.4%
4	Supervision or Touching Assistance	92	20.2%	18	19%	3	7.0%	4	8.2%
5	Setup or Clean-up Assistance	50	11.0%	11	11%	3	7.0%	7	14.3%
6	Independent	82	18.0%	23	24%	3	7.0%	3	6.1%
	QVIA2. Oral Hygiene								
0	Not attempted, not finished, or not applicable	10	2.1%	3	3%	1	2.0%	3	5.5%
1	Dependent	53	11.3%	10	10%	22	44.9%	15	27.3%
2	Substantial/Maximal Assistance	30	6.4%	2	2%	6	12.2%	11	20.0%
3	Partial/Moderate Assistance	25	5.3%	4	4%	3	6.1%	3	5.5%
4	Supervision or Touching Assistance	69	14.7%	13	14%	4	8.2%	4	7.3%
5	Setup or Clean-up Assistance	161	34.3%	29	30%	4	8.2%	13	23.6%
6	Independent	122	26.0%	35	36%	9	18.4%	6	10.9%
	QVIA3. Eating								
0	Not attempted, not finished, or not applicable	30	6.7%	3	3%	1	2.5%	14	29.2%
1	Dependent	29	6.4%	12	13%	10	25.0%	4	8.3%
2	Substantial/Maximal Assistance	18	4.0%	1	1%	3	7.5%	3	6.3%
3	Partial/Moderate Assistance	23	5.1%	2	2%	7	17.5%	2	4.2%
4	Supervision or Touching Assistance	39	8.6%	8	8%	2	5.0%	8	16.7%
5	Setup or Clean-up Assistance	123	27.3%	27	28%	7	17.5%	9	18.8%
6	Independent	189	41.9%	43	45%	10	25.0%	8	16.7%
	QVIA4. Tube Feeding								
0	Not attempted, not finished, or not applicable	237	67.7%	90	95%	—	—	17	37.8%
1	Dependent	89	25.4%	1	1%	52	91.2%	25	55.6%
2	Substantial/Maximal Assistance	9	2.6%	1	1%	3	5.3%	3	6.7%
3	Partial/Moderate Assistance	1	0.3%	—	—	—	—	—	—
4	Supervision or Touching Assistance	3	0.9%	—	—	—	—	—	—
5	Setup or Clean-up Assistance	4	1.1%	—	—	1	1.8%	—	—
6	Independent	7	2.0%	3	3%	1	1.8%	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QVIB1. Walk 50 ft								
0	Not attempted, not finished, or not applicable	105	29.3%	38	41%	2	25.0%	29	82.9%
1	Dependent	28	7.8%	2	2%	2	25.0%	—	—
2	Substantial/Maximal Assistance	3	0.8%	—	—	—	—	—	—
3	Partial/Moderate Assistance	23	6.4%	3	3%	3	37.5%	—	—
4	Supervision or Touching Assistance	103	28.8%	31	33%	—	—	2	5.7%
5	Setup or Clean-up Assistance	29	8.1%	7	8%	—	—	3	8.6%
6	Independent	67	18.7%	12	13%	1	12.5%	1	2.9%
	QVIB2. Walk in Room Once Standing								
0	Not attempted, not finished, or not applicable	71	18.6%	21	22%	1	8.3%	23	62.2%
1	Dependent	16	4.2%	3	3%	2	16.7%	1	2.7%
2	Substantial/Maximal Assistance	15	3.9%	1	1%	1	8.3%	3	8.1%
3	Partial/Moderate Assistance	41	10.8%	4	4%	5	41.7%	—	—
4	Supervision or Touching Assistance	137	36.0%	45	48%	2	16.7%	5	13.5%
5	Setup or Clean-up Assistance	26	6.8%	6	6%	—	—	4	10.8%
6	Independent	75	19.7%	14	15%	1	8.3%	1	2.7%
	QVIB3. Toilet Transfer								
0	Not attempted, not finished, or not applicable	51	12.8%	15	16%	1	11.1%	26	70.3%
1	Dependent	34	8.5%	5	5%	2	22.2%	2	5.4%
2	Substantial/Maximal Assistance	31	7.8%	3	3%	—	—	—	—
3	Partial/Moderate Assistance	65	16.3%	15	16%	2	22.2%	—	—
4	Supervision or Touching Assistance	112	28.1%	38	40%	1	11.1%	3	8.1%
5	Setup or Clean-up Assistance	26	6.5%	3	3%	3	33.3%	3	8.1%
6	Independent	79	19.8%	16	17%	—	—	3	8.1%
	QVIB4. Chair/Bed-to-Chair Transfer								
0	Not attempted, not finished, or not applicable	27	6.5%	12	13%	1	5.3%	11	27.5%
1	Dependent	40	9.6%	4	4%	7	36.8%	7	17.5%
2	Substantial/Maximal Assistance	45	10.8%	5	5%	2	10.5%	6	15.0%
3	Partial/Moderate Assistance	71	17.0%	16	17%	4	21.1%	4	10.0%
4	Supervision or Touching Assistance	124	29.7%	40	42%	4	21.1%	3	7.5%
5	Setup or Clean-up Assistance	26	6.2%	3	3%	—	—	6	15.0%
6	Independent	85	20.3%	15	16%	1	5.3%	3	7.5%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QVIB5. Sit to Stand								
0	Not attempted, not finished, or not applicable	31	7.6%	9	10%	1	5.6%	15	37.5%
1	Dependent	27	6.6%	6	7%	4	22.2%	5	12.5%
2	Substantial/Maximal Assistance	48	11.7%	4	4%	3	16.7%	6	15.0%
3	Partial/Moderate Assistance	61	14.9%	8	9%	5	27.8%	3	7.5%
4	Supervision or Touching Assistance	127	31.1%	46	50%	4	22.2%	4	10.0%
5	Setup or Clean-up Assistance	26	6.4%	1	1%	—	—	4	10.0%
6	Independent	89	21.8%	18	20%	1	5.6%	3	7.5%
	QVIB6. Lying to Sitting on Side of Bed								
0	Not attempted, not finished, or not applicable	24	5.5%	15	16%	1	3.3%	4	9.1%
1	Dependent	42	9.7%	9	9%	11	36.7%	12	27.3%
2	Substantial/Maximal Assistance	57	13.2%	6	6%	4	13.3%	5	11.4%
3	Partial/Moderate Assistance	80	18.5%	13	14%	7	23.3%	6	13.6%
4	Supervision or Touching Assistance	83	19.2%	33	35%	5	16.7%	7	15.9%
5	Setup or Clean-up Assistance	44	10.2%	2	2%	—	—	6	13.6%
6	Independent	103	23.8%	17	18%	2	6.7%	4	9.1%
	QVIB7. Use Wheelchair?								
0	No	374	79.4%	85	94%	54	84.4%	49	87.5%
1	Yes	97	20.6%	5	6%	10	15.6%	7	12.5%
	QVIB8. Wheel 50 ft - Interior								
0	Not attempted, please specify below	91	58.3%	50	93%	—	—	29	96.7%
1	Dependent	17	10.9%	1	2%	—	—	—	—
2	Substantial/Maximal Assistance	9	5.8%	—	—	—	—	—	—
3	Partial/Moderate Assistance	7	4.5%	—	—	—	—	—	—
4	Supervision or Touching Assistance	15	9.6%	1	2%	—	—	—	—
5	Setup or Clean-up Assistance	5	3.2%	—	—	1	100.0%	—	—
6	Independent	12	7.7%	2	4%	—	—	1	3.3%
	QVIB9. Wheel in Room Once Seated								
0	Not attempted, please specify below	87	54.0%	48	92%	—	—	29	93.5%
1	Dependent	14	8.7%	1	2%	—	—	—	—
2	Substantial/Maximal Assistance	7	4.3%	—	—	—	—	—	—
3	Partial/Moderate Assistance	17	10.6%	—	—	—	—	—	—
4	Supervision or Touching Assistance	14	8.7%	1	2%	—	—	1	3.2%
5	Setup or Clean-up Assistance	9	5.6%	—	—	1	100.0%	—	—
6	Independent	13	8.1%	2	4%	—	—	1	3.2%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QVIC1. Sponge Bath								
0	Not attempted, please specify below	38	16.0%	29	41%	1	2.0%	3	5.5%
1	Dependent	75	31.6%	10	14%	31	62.0%	24	43.6%
2	Substantial/Maximal Assistance	30	12.7%	6	9%	7	14.0%	4	7.3%
3	Partial/Moderate Assistance	34	14.3%	7	10%	5	10.0%	4	7.3%
4	Supervision or Touching Assistance	22	9.3%	8	11%	2	4.0%	8	14.5%
5	Setup or Clean-up Assistance	20	8.4%	6	9%	1	2.0%	8	14.5%
6	Independent	18	7.6%	4	6%	3	6.0%	4	7.3%
	QVIC2. Sit to Lying								
0	Not attempted, please specify below	40	16.3%	30	42%	2	3.5%	2	3.5%
1	Dependent	72	29.4%	11	15%	33	57.9%	20	35.1%
2	Substantial/Maximal Assistance	40	16.3%	4	6%	8	14.0%	9	15.8%
3	Partial/Moderate Assistance	27	11.0%	6	8%	5	8.8%	7	12.3%
4	Supervision or Touching Assistance	25	10.2%	10	14%	3	5.3%	7	12.3%
5	Setup or Clean-up Assistance	11	4.5%	1	1%	1	1.8%	5	8.8%
6	Independent	30	12.2%	10	14%	5	8.8%	7	12.3%
	QVIC3. Roll left or right								
0	Not attempted, please specify below	39	14.0%	29	40%	—	—	2	3.4%
1	Dependent	96	34.4%	8	11%	66	68.8%	15	25.4%
2	Substantial/Maximal Assistance	40	14.3%	3	4%	10	10.4%	12	20.3%
3	Partial/Moderate Assistance	26	9.3%	5	7%	9	9.4%	8	13.6%
4	Supervision or Touching Assistance	27	9.7%	11	15%	3	3.1%	5	8.5%
5	Setup or Clean-up Assistance	14	5.0%	4	6%	1	1.0%	8	13.6%
6	Independent	36	12.9%	12	17%	7	7.3%	8	13.6%
—	***out of range***	1	0.4%	—	—	—	—	1	1.7%
	QVID1. Upper Body Dressing								
0	Not attempted, please specify below	48	17.4%	40	51%	1	3.4%	3	7.5%
1	Dependent	30	10.9%	2	3%	11	37.9%	7	17.5%
2	Substantial/Maximal Assistance	40	14.5%	3	4%	6	20.7%	8	20.0%
3	Partial/Moderate Assistance	44	15.9%	7	9%	5	17.2%	8	20.0%
4	Supervision or Touching Assistance	36	13.0%	7	9%	3	10.3%	5	12.5%
5	Setup or Clean-up Assistance	42	15.2%	9	11%	1	3.4%	6	15.0%
6	Independent	36	13.0%	11	14%	2	6.9%	3	7.5%
	QVID2. Shower/Bathe Self								
0	Not attempted, please specify below	70	28.0%	43	54%	—	—	19	47.5%
1	Dependent	29	11.6%	3	4%	5	55.6%	7	17.5%
2	Substantial/Maximal Assistance	49	19.6%	7	9%	1	11.1%	4	10.0%
3	Partial/Moderate Assistance	42	16.8%	8	10%	—	—	3	7.5%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
4	Supervision or Touching Assistance	28	11.2%	9	11%	—	—	3	7.5%
5	Setup or Clean-up Assistance	17	6.8%	7	9%	3	33.3%	3	7.5%
6	Independent	15	6.0%	3	4%	—	—	1	2.5%
	QVID3. Picking up								
0	Not attempted, please specify below	126	55.8%	54	68%	1	10.0%	17	47.2%
1	Dependent	23	10.2%	6	8%	1	10.0%	4	11.1%
2	Substantial/Maximal Assistance	6	2.7%	2	3%	1	10.0%	2	5.6%
3	Partial/Moderate Assistance	15	6.6%	4	5%	2	20.0%	5	13.9%
4	Supervision or Touching Assistance	15	6.6%	5	6%	4	40.0%	2	5.6%
5	Setup or Clean-up Assistance	33	14.6%	7	9%	1	10.0%	5	13.9%
6	Independent	8	3.5%	1	1%	—	—	1	2.8%
	QVID4. I step (curb)								
0	Not attempted, please specify below	146	67.3%	68	86%	1	33.3%	26	76.5%
1	Dependent	7	3.2%	1	1%	—	—	2	5.9%
2	Substantial/Maximal Assistance	6	2.8%	3	4%	—	—	1	2.9%
3	Partial/Moderate Assistance	14	6.5%	1	1%	2	66.7%	1	2.9%
4	Supervision or Touching Assistance	15	6.9%	3	4%	—	—	1	2.9%
5	Setup or Clean-up Assistance	19	8.8%	—	—	—	—	2	5.9%
6	Independent	10	4.6%	3	4%	—	—	1	2.9%
	QVID5. Short ramp								
0	Not attempted, please specify below	109	84.5%	57	97%	—	—	27	90.0%
1	Dependent	11	8.5%	—	—	—	—	1	3.3%
2	Substantial/Maximal Assistance	0	0%	—	—	—	—	—	—
3	Partial/Moderate Assistance	1	0.8%	1	2%	—	—	—	—
4	Supervision or Touching Assistance	0	0%	—	—	—	—	—	—
5	Setup or Clean-up Assistance	3	2.3%	—	—	—	—	1	3.3%
6	Independent	5	3.9%	1	2%	—	—	1	3.3%
	QVIE1. Lower Body dressing								
0	Not attempted, please specify below	37	14.9%	27	38%	1	3.6%	5	12.8%
1	Dependent	27	10.9%	2	3%	13	46.4%	7	17.9%
2	Substantial/Maximal Assistance	32	12.9%	5	7%	5	17.9%	11	28.2%
3	Partial/Moderate Assistance	34	13.7%	8	11%	2	7.1%	5	12.8%
4	Supervision or Touching Assistance	52	21.0%	11	15%	3	10.7%	6	15.4%
5	Setup or Clean-up Assistance	23	9.3%	4	6%	3	10.7%	4	10.3%
6	Independent	43	17.3%	15	21%	1	3.6%	1	2.6%
	QVIE2. 12 steps-interior								
0	Not attempted, please specify below	125	67.2%	63	88%	1	33.3%	31	91.2%
1	Dependent	2	1.1%	—	—	—	—	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
2	Substantial/Maximal Assistance	1	0.5%	1	1%	—	—	—	—
3	Partial/Moderate Assistance	3	1.6%	1	1%	—	—	—	—
4	Supervision or Touching Assistance	16	8.6%	1	1%	—	—	1	2.9%
5	Setup or Clean-up Assistance	23	12.4%	4	6%	2	66.7%	1	2.9%
6	Independent	16	8.6%	2	3%	—	—	1	2.9%
	QVIE3. 4 steps-exterior								
0	Not attempted, please specify below	8	55.5%	58	83%	1	33.3%	31	91.2%
1	Dependent	0	0%	—	—	—	—	—	—
2	Substantial/Maximal Assistance	1	0.5%	1	1%	—	—	—	—
3	Partial/Moderate Assistance	6	3.0%	—	—	—	—	—	—
4	Supervision or Touching Assistance	39	19.5%	5	7%	—	—	1	2.9%
5	Setup or Clean-up Assistance	19	9.5%	3	4%	1	33.3%	1	2.9%
6	Independent	24	12.0%	3	4%	1	33.3%	1	2.9%
	QVIE4. Walk longer distances-interior								
0	Not attempted, please specify below	87	43.3%	45	63%	1	33.3%	30	88.2%
1	Dependent	2	1.0%	2	3%	—	—	—	—
2	Substantial/Maximal Assistance	1	0.5%	—	—	—	—	—	—
3	Partial/Moderate Assistance	5	2.5%	—	—	1	33.3%	—	—
4	Supervision or Touching Assistance	48	23.9%	14	19%	—	—	1	2.9%
5	Setup or Clean-up Assistance	19	9.5%	4	6%	—	—	2	5.9%
6	Independent	39	19.4%	7	10%	1	33.3%	1	2.9%
	QVIE5. Wheel longer distances-interior								
0	Not attempted, please specify below	85	84.2%	51	94%	—	—	27	90.0%
1	Dependent	3	3.0%	1	2%	1	100.0%	1	3.3%
2	Substantial/Maximal Assistance	1	1.0%	—	—	—	—	1	3.3%
3	Partial/Moderate Assistance	—	—	—	—	—	—	—	—
4	Supervision or Touching Assistance	4	4.0%	—	—	—	—	—	—
5	Setup or Clean-up Assistance	2	2.0%	—	—	—	—	—	—
6	Independent	6	5.9%	2	4%	—	—	1	3.3%
	QVIE6. Long ramp-exterior								
0	Not attempted, please specify below	90	93.8%	52	98%	—	—	28	96.6%
1	Dependent	1	1.0%	—	—	1	100.0%	—	—
2	Substantial/Maximal Assistance	0	0%	—	—	—	—	—	—
3	Partial/Moderate Assistance	0	0%	—	—	—	—	—	—
4	Supervision or Touching Assistance	0	0%	—	—	—	—	—	—
5	Setup or Clean-up Assistance	0	0%	—	—	—	—	—	—
6	Independent	5	5.2%	1	2%	—	—	1	3.4%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QVIF1. Laundry								
0	Not attempted, please specify below	96	73.8%	60	94%	—	—	32	97.0%
1	Dependent (Total Assistance)	7	5.4%	1	2%	—	—	1	3.0%
2	Maximum Assistance	9	6.9%	1	2%	—	—	—	—
3	Minimal Assistance	9	6.9%	1	2%	1	100.0%	—	—
4	Independent	9	6.9%	1	2%	—	—	—	—
	QVIF2. Make light meal								
0	Not attempted, please specify below	94	71.2%	59	92%	—	—	31	93.9%
1	Dependent (Total Assistance)	4	3.0%	1	2%	—	—	1	3.0%
2	Maximum Assistance	4	3.0%	2	3%	—	—	—	—
3	Minimal Assistance	12	9.1%	1	2%	1	100.0%	1	3.0%
4	Independent	18	13.6%	1	2%	—	—	—	—
	QVIF3. Dishwashing-By Hand								
0	Not attempted, please specify below	93	72.1%	58	91%	—	—	31	93.9%
1	Dependent (Total Assistance)	4	3.1%	1	2%	—	—	1	3.0%
2	Maximum Assistance	6	4.7%	3	5%	—	—	—	—
3	Minimal Assistance	9	7.0%	1	2%	—	—	—	—
4	Independent	12	9.3%	—	—	1	100.0%	1	3.0%
—	***out of range***	5	3.9%	1	2%	—	—	—	—
	QVIF4. Dishwashing-Machine								
0	Not attempted, please specify below	97	76.4%	59	92%	1	100.0%	31	93.9%
1	Dependent (Total Assistance)	2	1.6%	—	—	—	—	1	3.0%
2	Maximum Assistance	6	4.7%	1	2%	—	—	—	—
3	Minimal Assistance	8	6.3%	3	5%	—	—	—	—
4	Independent	14	11.0%	1	2%	—	—	1	3.0%
	QVIF5. Wipe down surface								
0	Not attempted, please specify below	80	60.6%	59	92%	—	—	17	50.0%
1	Dependent (Total Assistance)	3	2.3%	—	—	—	—	2	5.9%
2	Maximum Assistance	3	2.3%	1	2%	—	—	1	2.9%
3	Minimal Assistance	20	15.2%	3	5%	1	100.0%	12	35.3%
4	Independent	26	19.7%	1	2%	—	—	2	5.9%
	QVIF6. Telephone-Answering								
0	Not attempted, please specify below	70	51.1%	55	86%	—	—	13	36.1%
1	Dependent (Total Assistance)	3	2.2%	1	2%	—	—	2	5.6%
2	Maximum Assistance	6	4.4%	1	2%	—	—	5	13.9%
3	Minimal Assistance	13	9.5%	—	—	—	—	10	27.8%
4	Independent	37	27.0%	6	9%	—	—	6	16.7%
—	***out of range***	8	5.8%	1	2%	1	100.0%	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QVIF7. Telephone-Placing Call								
0	Not attempted, please specify below	72	52.6%	57	89%	—	—	13	36.1%
1	Dependent (Total Assistance)	3	2.2%	—	—	—	—	3	8.3%
2	Maximum Assistance	6	4.4%	1	2%	—	—	4	11.1%
3	Minimal Assistance	11	8.0%	—	—	—	—	10	27.8%
4	Independent	45	32.8%	6	9%	1	100.0%	6	16.7%
	QVIF8. Medication Management - Oral Medications								
0	Not attempted, please specify below	79	59.8%	59	92%	—	—	18	51.4%
1	Dependent (Total Assistance)	6	4.5%	1	2%	—	—	3	8.6%
2	Maximum Assistance	5	3.8%	1	2%	—	—	2	5.7%
3	Minimal Assistance	13	9.8%	1	2%	1	100.0%	7	20.0%
4	Independent	28	21.2%	2	3%	—	—	4	11.4%
—	***out of range***	1	0.8%	—	—	—	—	1	2.9%
	QVIF9. Medication Management-Inhalation/Mist Medications								
0	Not attempted, please specify below	102	82.3%	59	94%	1	100.0%	31	86.1%
1	Dependent (Total Assistance)	2	1.6%	—	—	—	—	2	5.6%
2	Maximum Assistance	3	2.4%	1	2%	—	—	1	2.8%
3	Minimal Assistance	6	4.8%	2	3%	—	—	1	2.8%
4	Independent	10	8.1%	—	—	—	—	1	2.8%
—	***outside correct range***	1	0.8%	1	2%	—	—	—	—
	QVIF10. Medication Management-Injectable Medications								
0	Not attempted, please specify below	110	90.9%	62	97%	1	100.0%	32	88.9%
1	Dependent (Total Assistance)	5	4.1%	1	2%	—	—	2	5.6%
2	Maximum Assistance	4	3.3%	1	2%	—	—	2	5.6%
3	Minimal Assistance	—	—	—	—	—	—	—	—
4	Independent	2	1.7%	—	—	—	—	—	—
	QVIG1. Get in/out of car								
0	Not attempted, please specify below	86	81.1%	56	90%	—	—	30	93.8%
1	Dependent (Total Assistance)	1	0.9%	—	—	—	—	1	3.1%
2	Maximum Assistance	2	1.9%	1	2%	—	—	—	—
3	Minimal Assistance	5	4.7%	4	6%	—	—	—	—
4	Independent	12	11.3%	1	2%	—	—	1	3.1%
	QVIG2. Light shopping								
0	Not attempted, please specify below	87	82.1%	56	90%	—	—	30	93.8%
1	Dependent (Total Assistance)	4	3.8%	2	3%	—	—	1	3.1%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
2	Maximum Assistance	2	1.9%	2	3%	—	—	—	—
3	Minimal Assistance	4	3.8%	1	2%	—	—	—	—
4	Independent	9	8.5%	1	2%	—	—	1	3.1%
	QVIG3. Walk a block								
0	Not attempted, please specify below	88	83.0%	59	95%	—	—	29	90.6%
1	Dependent (Total Assistance)	1	0.9%	—	—	—	—	1	3.1%
2	Maximum Assistance	2	1.9%	2	3%	—	—	—	—
3	Minimal Assistance	4	3.8%	—	—	—	—	1	3.1%
4	Independent	10	9.4%	—	—	—	—	1	3.1%
—	outside correct range	1	0.9%	1	2%	—	—	—	—
	QVIG4. Use Public Transportation								
0	Not attempted, please specify below	91	89.2%	60	97%	—	—	30	93.8%
1	Dependent (Total Assistance)	1	1.0%	—	—	—	—	1	3.1%
2	Maximum Assistance	1	1.0%	1	2%	—	—	—	—
3	Minimal Assistance	2	2.0%	—	—	—	—	—	—
4	Independent	7	6.9%	1	2%	—	—	1	3.1%
	QVIG5. Drive a car								
0	Not attempted, please specify below	89	91.8%	59	97%	—	—	29	96.7%
1	Dependent (Total Assistance)	3	3.1%	—	—	—	—	1	3.3%
2	Maximum Assistance	1	1.0%	1	2%	—	—	—	—
3	Minimal Assistance	0	0%	—	—	—	—	—	—
4	Independent	4	4.1%	1	2%	—	—	—	—
	QVIG6. Wheel a block								
0	Not attempted, please specify below	76	96.2%	51	98%	—	—	25	92.6%
1	Dependent (Total Assistance)	1	1.3%	—	—	—	—	1	3.7%
2	Maximum Assistance	0	0%	—	—	—	—	—	—
3	Minimal Assistance	1	1.3%	1	2%	—	—	—	—
4	Independent	1	1.3%	—	—	—	—	1	3.7%
	QVIH1. Surprised at patient readmittance to hospital in next 3-6 months?								
0	No	282	54.5%	42	46%	58	58.6%	37	61.7%
1	Yes	208	40.2%	50	54%	35	35.4%	13	21.7%
9	Not assessed/don't know	27	5.2%	—	—	6	6.1%	10	16.7%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QVIH2. Surprised if patient dies in next 6-12 months?								
0	No	129	24.9%	14	15%	49	50.5%	22	36.7%
1	Yes	337	65.1%	67	72%	37	38.1%	26	43.3%
9	Not assessed/don't know	52	10.0%	12	13%	11	11.3%	12	20.0%
	VII. Discharge Status								
	QVIIB1. Discharge location								
1	Private residence	120	49.8%	42	44%	—	—	3	8.1%
2	Other community-based residence setting	5	2.1%	3	3%	—	—	—	—
3	Long-term care facility/nursing home	9	3.7%	5	5%	—	—	3	8.1%
4	Skilled nursing facility	62	25.7%	34	35%	—	—	11	29.7%
5	Inpatient rehabilitation hospital or unit	13	5.4%	8	8%	—	—	4	10.8%
6	Long-term care hospital	0	0%	—	—	—	—	—	—
7	Short-stay acute hospital	17	7.1%	2	2%	—	—	8	21.6%
8	Hospice care	2	0.8%	1	1%	—	—	1	2.7%
9	Psychiatric Hospital or unit	1	0.4%	1	1%	—	—	—	—
10	Other	5	2.1%	—	—	—	—	—	—
11	Discharged against medical advice	0	0%	—	—	—	—	—	—
12	Expired	7	2.9%	—	—	—	—	7	18.9%
	QVIIB2. Structural Barrier								
B2a	Structural barriers are not an issue.	93	54.7%	47	76%	—	—	6	85.7%
B2b	Stairs inside the living setting that must be used by patient (e.g., to get to toileting, sleeping, eating areas).	20	11.8%	8	13%	—	—	—	—
B2c	Stairs leading from inside to outside of living setting.	23	13.5%	3	5%	—	—	1	14.3%
B2b, B2c	Stairs inside the living setting that must be used by patient (e.g., to get to toileting, sleeping, eating areas) AND Stairs leading from inside to outside of living setting.	31	18.2%	3	5%	—	—	—	—
B2d	Narrow or obstructed doorways	0	0%	—	—	—	—	—	—
B2c, B2d	Stairs leading from inside to outside of living setting AND Narrow or obstructed doorways for patients using wheelchairs or walkers.	2	1.2%	—	—	—	—	—	—
B2e	Insufficient space to accommodate extra equipment (e.g. hospital bed, vent equipment)	0	0%	—	—	—	—	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
B2b, B2c, B2d, B2e	Stairs inside the living setting that must be used by patient AND Stairs leading from inside to outside AND Narrow or obstructed doorways AND Insufficient space to accommodate extra equipment (e.g. hospital bed, vent equipment)	1	0.6%	1	2%	—	—	—	—
	QVIIC1. Live With on Discharge								
C1a	Will live Alone	24	18.6%	7	15%	—	—	—	—
C1b	Spouse or Significant other.	51	39.5%	20	43%	—	—	1	50.0%
C1c	Adult child (> 18 years).	24	18.6%	8	17%	—	—	1	50.0%
C1b, C1c	Spouse or Significant other AND Adult child (> 18 years).	11	8.5%	5	11%	—	—	—	—
C1d	Other unpaid family member or friend.	3	2.3%	1	2%	—	—	—	—
C1a, C1d	Will live Alone AND Other unpaid family member or friend.	1	0.8%	1	2%	—	—	—	—
C1b, C1d	Spouse or Significant other AND Other unpaid family member or friend.	1	0.8%	—	—	—	—	—	—
C1c, C1d	Adult child (>18 years) AND Other unpaid family member or friend.	2	1.6%	1	2%	—	—	—	—
C1e	Paid help, other than home care agency.	8	6.2%	2	4%	—	—	—	—
C1a, C1e	Will live Alone AND Paid help other than home care agency	1	0.8%	1	2%	—	—	—	—
C1b, C1e	Spouse or Significant other AND Paid help, other than home care agency	2	1.6%	—	—	—	—	—	—
C1d, C1e	Other unpaid family member or friend AND Paid help other than home care agency	1	0.8%	1	2%	—	—	—	—
	QVIIC2. Frequency of Assistance								
1	Does not require assistance	12	8.5%	4	8%	—	—	—	—
2	Weekly or less	27	19.1%	11	23%	—	—	—	—
3	Less than daily but more often than weekly	12	8.5%	6	13%	—	—	—	—
4	Intermittently during the day or night	56	39.7%	18	38%	—	—	4	57.1%
5	All night but not during the day	—	—	—	—	—	—	—	—
6	All day but not at night	4	2.8%	2	4%	—	—	—	—
7	24 hours per day	30	21.3%	7	15%	—	—	3	42.9%

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	QVIIC3. Caregiver Availability								
0	No	17	12.5%	5	11%	—	—	3	37.5%
1	Yes	119	87.5%	40	89%	—	—	5	62.5%
	QVIIC4. Type of Caregiver								
C4a	Spouse or Significant other.	49	39.5%	18	41%	—	—	1	50.0%
C4b	Adult child (> 18 years).	36	29.0%	9	20%	—	—	1	50.0%
C4a, C4b	Spouse or Significant other AND Adult child (>18 years)	12	9.7%	8	18%	—	—	—	—
C4c	Other unpaid family member or friend.	7	5.6%	3	7%	—	—	—	—
C4a, C4c	Spouse or Significant other AND Other unpaid family member or friend.	1	0.8%	—	—	—	—	—	—
C4b, C4c	Adult child (> 18 years) AND Other unpaid family member or friend	5	4.0%	1	2%	—	—	—	—
C4d	Paid help, other than home care agency.	12	9.7%	4	9%	—	—	—	—
C4a, C4d	Spouse or Significant other AND Paid help, other than home care agency	1	0.8%	—	—	—	—	—	—
C4c, C4d	Other unpaid family member or friend AND Paid help, other than home care agency	1	0.8%	1	2%	—	—	—	—
	QVIIC5A. Able to pay for meds								
0	Unable to assess	16	10.6%	7	14%	—	—	5	50.0%
1	No	9	6.0%	3	6%	—	—	—	—
2	Yes	79	52.3%	21	41%	—	—	2	20.0%
3	Unknown	47	31.1%	20	39%	—	—	3	30.0%
	QVIIC5B. Transport to clinic								
0	Unable to assess	5	3.6%	3	6%	—	—	1	16.7%
1	No follow up physician appointments and/or outpatient therapies or treatments planned	3	2.1%	2	4%	—	—	1	16.7%
2	Can drive self	8	5.7%	4	8%	—	—	—	—
3	Family member or friend will drive patient	110	78.6%	40	80%	—	—	2	33.3%
4	Public transportation	—	—	—	—	—	—	—	—
5	Other	14	10.0%	1	2%	—	—	2	33.3%
	QVIID1. HHA PAC								
1	Deemed Appropriate by the Provider.	72	96.0%	23	88%	—	—	—	—
2	Bed Available.	0	0%	—	—	—	—	—	—
4	Refused by Patient/Family.	3	4.0%	3	12%	—	—	—	—

(continued)

Table E-1a (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
AH and LTCH

Code	Value Choices	Total Pilot Respondents	Pilot % Distribution	AH Respondents to Question	AH Discharge % Distribution	LTCH Admission Respondents to Question	LTCH Admission % Distribution	LTCH Discharge Respondents to Question	LTCH Discharge % Distribution
	AVIID2. SNF PAC								
1	Deemed Appropriate by the Provider.	57	90.5%	38	93%	—	—	8	88.9%
2	Bed Available.	4	6.3%	2	5%	—	—	1	11.1%
4	Refused by Patient/Family.	2	3.2%	1	2%	—	—	—	—
	QVIID3. IRF PAC								
1	Deemed Appropriate by the Provider.	14	87.5%	9	90%	—	—	4	100.0%
2	Bed Available.	1	6.3%	1	10%	—	—	—	—
4	Refused by Patient/Family.	1	6.3%	—	—	—	—	—	—
	QVIID4. LTCH PAC								
1	Deemed Appropriate by the Provider.	2	66.7%	—	—	—	—	—	—
2	Bed Available.	0	0%	—	—	—	—	—	—
4	Refused by Patient/Family.	1	33.3%	—	—	—	—	—	—
	QVIID5. PSYCH PAC								
1	Deemed Appropriate by the Provider.	0	0%	—	—	—	—	—	—
2	Bed Available.	1	100.0%	1	100%	—	—	—	—
4	Refused by Patient/Family.	0	0%	—	—	—	—	—	—
	QVIID6. OTHER PAC								
1	Deemed Appropriate by the Provider.	37	94.9%	7	100%	—	—	5	83.3%
2	Bed Available.	2	5.1%	—	—	—	—	1	16.7%
4	Refused by Patient/Family.	0	0%	—	—	—	—	—	—
	QVIID7B. Discharge Provider Type								
—	HHA	3	2.3%	—	—	—	—	—	—
—	SNF	18	14.0%	8	13%	—	—	8	50.0%
—	IRF	60	46.5%	35	58%	—	—	8	50.0%
—	LTCH	48	37.2%	17	28%	—	—	—	—
	QVIIE1. Patient discharge delayed								
0	No	189	85.5%	74	79%	—	—	25	100.0%
1	Yes	32	14.5%	20	21%	—	—	—	—
	QVIIE2. Reason for Discharge Delay								
1	No bed available	5	15.2%	4	19%	—	—	—	—
2	Services, equipment or medications not available	1	3.0%	—	—	—	—	—	—
3	Family/support	2	6.1%	—	—	—	—	—	—
4	Medical	16	48.5%	12	57%	—	—	—	—
5	Other	9	27.3%	5	24%	—	—	—	—

Table E-1b
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	I. Administrative Items								
	QIA8. Gender								
1	Male	42	42%	41	43%	20	45%	—	—
2	Female	58	58%	54	57%	24	55%	2	100%
	QIA9. Ethnicity								
1	American Indian or Alaska Native	—	—	—	—	—	—	—	—
2	Asian	—	—	—	—	—	—	—	—
3	Black or African American	3	3%	3	3%	15	35%	1	50%
4	Hispanic or Latino	2	2%	3	3%	1	2%	—	—
5	Native Hawaiian or Pacific Islander	9	9%	—	—	—	—	—	—
6	White	84	84%	82	89%	27	63%	1	50%
2, 6	White and Asian	1	1%	1	1%	—	—	—	—
7	Unknown	1	1%	3	3%	—	—	—	—
	QIA10. Educational Level								
1	Less than 1 year of high school	9	9%	12	13%	15	36%	—	—
2	High School Graduate or GED	34	35%	32	35%	15	36%	—	—
3	Some college	31	32%	26	28%	8	19%	—	—
4	Four-year college degree	13	14%	15	16%	2	5%	—	—
5	More than 4 years of college	9	9%	7	8%	2	5%	2	100%
	QIA11. Advanced Directive								
0	No	60	61%	57	60%	37	88%	1	50%
1	Yes	38	39%	38	40%	5	12%	1	50%
	QIA12. Durable Power of Attorney								
0	No	70	72%	67	69%	34	81%	1	50%
1	Yes	27	28%	30	31%	8	19%	1	50%
	QIA13. Code Status Documented								
0	No	66	67%	50	52%	37	95%	1	100%
1	Yes	33	33%	46	48%	2	5%	—	—
B1a	Q1B1. Current Payment Source	—	—	—	—	—	—	—	—
B1b	Medicare (traditional fee-for-service)	27	27%	—	—	32	74%	—	—
B1c	Medicare (HMO/Managed Care)	—	—	—	—	—	—	—	—
B1d	Medicaid (traditional fee-for-service)	—	—	—	—	—	—	—	—
B1d, B1b	Medicaid (traditional fee-for-service) AND Medicare (traditional fee-for-service)	8	8%	—	—	2	5%	—	—
B1e	Medicaid (HMO/Managed care)	—	—	—	—	—	—	—	—
B1e, B1b	Medicaid (HMO/Managed care) AND Medicare (traditional fee-for-service)	—	—	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
B1f	Workers' compensation	—	—	—	—	—	—	—	—
B1g	Title programs (e.g., Title III, V, or XX)	—	—	—	—	—	—	—	—
B1h	Other government (e.g., CHAMPUS, VA, etc.)	—	—	—	—	—	—	—	—
B1i	Private insurance	1	1%	—	—	—	—	—	—
B1i, B1d	Private insurance AND Medicare (traditional fee-for-service)	63	64%	—	—	—	—	—	—
B1i, B1c	Private insurance AND Medicare (HMO/Managed care)	—	—	—	—	—	—	—	—
B1i, B1d	Private insurance AND Medicaid (traditional fee-for-service)	—	—	—	—	—	—	—	—
B1j, B1b	Private HMO/managed care AND Medicare (traditional fee-for-service)	—	—	—	—	—	—	—	—
B1k, B1d, B1b	Self-pay AND Medicaid (traditional fee-for-service) AND Medicare (traditional fee-for-service)	—	—	—	—	—	—	—	—
B1l	Other	—	—	—	—	—	—	—	—
B1l, B1b	Other AND Medicare (traditional fee-for-service)	—	—	—	—	9	21%	—	—
B1l, B1c	Other AND Medicare (HMO/managed care)	—	—	—	—	—	—	—	—
B1l, B1d	Other AND Medicaid (traditional fee-for-service)	—	—	—	—	—	—	—	—
B1m	Unknown	—	—	—	—	—	—	—	—
	II. Admission Information								
	QIIA2. Admitted From								
1	Private residence	13	14%	—	—	3	7%	—	—
2	Community-based residence (e.g., assisted living residence, group home, adult foster care)	—	—	—	—	—	—	—	—
3	Long-term care facility/nursing home	—	—	—	—	—	—	—	—
4	Skilled nursing facility (includes subacute) (SNF/TCU)	4	4%	—	—	3	7%	—	—
5	Short-stay acute hospital. (IPPS)	78	82%	—	—	38	86%	—	—
6	Long-term care hospital. (LTCH)	—	—	—	—	—	—	—	—
7	Inpatient rehabilitation hospital or unit	—	—	—	—	—	—	—	—
8	Psychiatric Hospital or unit	—	—	—	—	—	—	—	—
9	Hospice	—	—	—	—	—	—	—	—
10	Other	—	—	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QIIA4. Prior Services								
A4a	Skilled nursing facility (includes subacute)	3	14%	—	—	4	25%	—	—
A4b	Inpatient rehabilitation hospital or unit	4	19%	—	—	1	6%	—	—
A4c	Long-term care hospital	—	—	—	—	—	—	—	—
A4d	Psychiatric Hospital or unit	—	—	—	—	—	—	—	—
A4a, A4b, A4c	Skilled nursing facility (includes subacute) AND inpatient rehabilitation hospital or unit AND and long-term care hospital	—	—	—	—	—	—	—	—
A4e	Acute short admission hospital	11	52%	—	—	5	31%	—	—
A4a, A4e	Skilled nursing facility (includes subacute) AND acute short admission hospital	2	10%	—	—	1	6%	—	—
A4a, A4b, A4c, A4e	Skilled nursing faciltiy (includes subacute) AND inpatient rehabilitation hospital or unit AND long-term care hospital AND acute short admission hospital	—	—	—	—	—	—	—	—
A4f	Home health	1	5%	—	—	4	25%	—	—
A4a, A4f	Skilled nursing facility (includes subacute) AND Home health	—	—	—	—	—	—	—	—
A4b, A4f	Inpatient rehabilitation hospital or unit AND Home health	—	—	—	—	1	6%	—	—
A4e, A4f	Acute short admission hospital AND Home health	—	—	—	—	—	—	—	—
A4a, A4e, A4f	Skilled nursing facility (includes subacute) AND acute short admission hospital AND home health	—	—	—	—	—	—	—	—
	QIIA5. Prior Residence								
1	Private residence	92	98%	—	—	32	78%	—	—
2	Community-based residence	1	1%	—	—	8	20%	—	—
3	Permanently in a long-term care facility	—	—	—	—	1	2%	—	—
4	Other	1	1%	—	—	—	—	—	—
	QIIA7. Lives with								
A7a	Lives Alone	31	33%	—	—	13	32%	—	—
A7b	Spouse or Significant other	41	44%	—	—	10	24%	—	—
A7c	Adult child (> 18 years)	10	11%	—	—	10	24%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
A7b, A7c	Spouse or Significant other AND Adult child (> 18 years)	3	3%	—	—	1	2%	—	—
A7d	Other unpaid family member or friend	5	5%	—	—	6	15%	—	—
A7c, A7d	Adult child (> 18 years) AND Other unpaid family member or friend	1	1%	—	—	—	—	—	—
A7e	Paid help living in the home (other than home care)	1	1%	—	—	1	2%	—	—
A7b, A7e	Spouse or Significant other AND Paid help living in the home (other than home care)	1	1%	—	—	—	—	—	—
A7d, A7e	Other unpaid family member or friend AND Paid help living in the home (other than home care)	—	—	—	—	—	—	—	—
	QIIA8A. Prior Function Self Care								
3	Independent	73	85%	—	—	14	31%	—	—
2	Needed Some Help	12	14%	—	—	25	56%	—	—
1	Dependent	1	1%	—	—	6	13%	—	—
9	Not applicable	—	—	—	—	—	—	—	—
	QIIA8B. Prior Function Mobility								
3	Independent	71	82%	—	—	17	38%	—	—
2	Needed Some Help	12	14%	—	—	18	40%	—	—
1	Dependent	4	5%	—	—	9	20%	—	—
9	Not applicable	—	—	—	—	1	2%	—	—
	QIIA8C. Prior Function Cognition								
3	Independent	69	78%	—	—	15	33%	—	—
2	Needed Some Help	13	15%	—	—	21	47%	—	—
1	Dependent	2	2%	—	—	6	13%	—	—
9	Not applicable	4	5%	—	—	3	7%	—	—
	QIIA9. Change in mental status								
0	No	61	70%	—	—	31	70%	—	—
1	Yes	22	25%	—	—	11	25%	—	—
9	Unknown	4	5%	—	—	2	5%	—	—
	QIIA10. History of Incontinence								
0	No	65	71%	—	—	26	58%	—	—
1	Bladder only	12	13%	—	—	5	11%	—	—
2	Bowel only	1	1%	—	—	1	2%	—	—
3	Bladder and bowel	8	9%	—	—	9	20%	—	—
9	Unknown	6	7%	—	—	4	9%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	III. Current Medical Items								
	QIIIC1. Diagnostic Procedures during Admission?								
0	No	—	—	28	34%	—	—	2	100%
1	Yes	—	—	54	66%	—	—	—	—
	QIIID1. None								
1	At Discharge	76	100%	81	94%	31	100%	1	33%
2	Anytime during stay	—	—	5	6%	—	—	2	67%
	QIIID2. Insulin Drip								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID3. Total Parenteral Nutrition								
1	At Discharge	1	100%	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID4. Central Line Management								
1	At Discharge	4	100%	3	38%	1	100%	—	—
2	Anytime during stay	—	—	5	63%	—	—	—	—
	QIIID5. Blood Transfusion(s)								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID6. Controlled Parenteral Analgesia - Peripheral								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	1	100%	—	—	—	—
	QIIID7. Controlled Parenteral Analgesia - Epidural								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID8. Left Ventricular Assistive Device (LVAD)								
1	At Discharge	—	—	—	—	1	100%	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID9. Continuous Cardiac Monitoring								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID10. Chest Tube(s)								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QIIID11. ET Tube Care and								
1	Management	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID12. Trach Tube with Suctioning:								
1	At Discharge	1	100%	1	100%	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID13. High O2 Concentration Delivery System with Fi)2 > 40%								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID14. Ventilator - Weaning								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID15. ventilator - Non-Weaning								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID16. Hemodialysis								
1	At Discharge	2	100%	—	—	5	100%	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID18. Peritoneal Dialysis								
1	At Discharge	—	—	—	—	2	100%	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID19. Fistula or Other Drain Management								
1	At Discharge	—	—	—	—	1	100%	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID20. Negative Pressure Wound Therapy								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID23. One-on-one 24-Hour Supervision								
1	At Discharge	—	—	—	—	—	—	—	—
2	Anytime during stay	—	—	—	—	—	—	—	—
	QIIID24. Specialty Bed								
1	At Discharge	6	100%	1	50%	4	100%	1	100%
2	Anytime during stay	—	—	1	50%	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QIIIF1. Allergy Status								
0	No known	—	—	48	61%	—	—	1	33%
1	Yes	—	—	31	39%	—	—	2	67%
	QIIIG1A. Pressure Ulcer Risk Assessment								
0	No	23	24%	11	11%	1	2%	—	—
1	Yes, it indicated not high risk	62	65%	81	83%	31	70%	2	50%
2	Yes, it indicated high risk	11	11%	6	6%	12	27%	2	50%
	QIIIG1B. Presence of Pressure Ulcer								
0	No	81	84%	81	88%	38	86%	3	75%
1	Yes	15	16%	11	12%	6	14%	1	25%
	QIIIG2A. Unhealed Pressure Ulcer Stg2								
0	No unhealed ulcers at this stage	9	45%	9	50%	22	92%	1	100%
1	One unhealed ulcer at this stage	10	50%	7	39%	2	8%	—	—
2	Two unhealed ulcers at this stage	1	5%	1	6%	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	1	6%	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2B. Stg2 Pressure Ulcers found this admission								
0	No unhealed ulcers at this stage	—	—	—	—	—	—	—	—
1	One unhealed ulcer at this stage	—	—	12	71%	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	5	29%	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2C. Unhealed Pressure Ulcers Stg3								
0	No unhealed ulcers at this stage	12	80%	10	91%	23	96%	1	100%
1	One unhealed ulcer at this stage	3	20%	—	—	1	4%	—	—
2	Two unhealed ulcers at this stage	—	—	1	9%	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2D. Stg3 Pressure Ulcers found this admission								
0	No unhealed ulcers at this stage	—	—	8	80%	—	—	—	—
1	One unhealed ulcer at this stage	—	—	1	10%	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	1	10%	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2E. Unhealed Pressure Ulcers Stg4								
0	No unhealed ulcers at this stage	12	92%	8	89%	22	92%	—	—
1	One unhealed ulcer at this stage	1	8%	1	11%	2	8%	1	100%
2	Two unhealed ulcers at this stage	—	—	—	—	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2F. Stg4 Pressure Ulcers found this admission								
0	No unhealed ulcers at this stage	—	—	9	100%	—	—	—	—
1	One unhealed ulcer at this stage	—	—	—	—	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	—	—	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2G. Unhealed Pressure Ulcers unstageable								
0	No unhealed ulcers at this stage	13	87%	9	90%	20	83%	1	100%
1	One unhealed ulcer at this stage	1	7%	1	10%	4	17%	—	—
2	Two unhealed ulcers at this stage	1	7%	—	—	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG2H. Unstageable Pressure Ulcers found this admission								
0	No unhealed ulcers at this stage	—	—	9	100%	—	—	—	—
1	One unhealed ulcer at this stage	—	—	—	—	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	—	—	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—	—	—	—	—
	QIIIG5. Ulcers with Tunneling								
0	No	13	87%	13	87%	16	94%	—	—
1	Yes	2	13%	1	7%	—	—	1	100%
9	Unable to assess	—	—	1	7%	1	6%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QIIIG6. Major wound present								
0	No	49	91%	54	96%	30	83%	4	100%
1	Yes	5	9%	2	4%	6	17%	—	—
	QIIIG8. Turning Surfaces								
	None - Skin for all turning surfaces are								
G8a	intact	19	61%	29	66%	12	75%	—	—
G8b	Right Hip	2	6%	2	5%	1	6%	—	—
G8c	Left Hip	4	13%	6	14%	1	6%	—	—
G8b, G8c	Right Hip AND Left Hip	—	—	1	2%	—	—	—	—
G8d	Back/Buttocks	5	16%	6	14%	2	13%	1	100%
G8b, G8d	Right Hip AND Back/Buttocks	—	—	—	—	—	—	—	—
G8c, G8d	Left Hip AND Back/Buttocks	1	3%	—	—	—	—	—	—
G8b, G8c,	Right Hip AND Left Hip AND								
G8d	Back/Buttocks	—	—	—	—	—	—	—	—
	IV. Cognitive Status								
	QIVA1. Patient Comatose								
0	No	90	95%	97	100%	42	98%	2	100%
1	Yes	5	5%	—	—	1	2%	—	—
	QIVB1. BIMS Attempted								
0	No	5	6%	33	34%	4	10%	—	—
1	Yes	85	94%	64	66%	38	90%	2	100%
	QIVB1A. Reason for no BiMS								
1	unresponsive	2	22%	—	—	—	—	—	—
2	communication disorder	1	11%	—	—	1	33%	—	—
3	no interpreter available	3	33%	8	21%	—	—	—	—
4	other	3	33%	30	79%	2	67%	—	—
	QIVB2. Repetition of Three Words								
—	None	—	—	—	—	9	23%	—	—
—	One	—	—	—	—	—	—	—	—
—	Two	6	7%	—	—	1	3%	—	—
—	Three	85	93%	64	100%	30	75%	2	100%
—	***out of range***	—	—	—	—	—	—	—	—
	QIVB3A. Current Year?								
	Missed by more than 5 years or no								
—	answer	4	4%	1	2%	8	20%	—	—
—	Missed by 2 to 5 years	—	—	—	—	—	—	—	—
—	Missed by 1 year	1	1%	—	—	2	5%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
—	Correct	85	94%	60	98%	31	76%	2	100%
—	***out of range***	—	—	—	—	—	—	—	—
	QIVB3B. Current Month								
—	Missed by more than 1 month	3	3%	1	2%	10	24%	—	—
—	Missed by 6 days to 1 month	4	5%	6	10%	10	24%	1	50%
—	Accurate within 5 days	81	92%	56	89%	21	51%	1	50%
—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—
	QIVB4. Recalls Sock								
—	No, could not recall	14	16%	5	8%	14	35%	1	50%
—	Yes, after cueing ("something to wear")	12	13%	4	6%	10	25%	1	50%
—	Yes, no cue required	64	71%	55	86%	16	40%	—	—
—	—	—	—	—	—	—	—	—	—
	QIVB5. Recalls Blue								
—	No, could not recall	6	7%	3	5%	12	30%	—	—
—	Yes, after cueing ("a color")	18	20%	3	5%	9	23%	2	100%
—	Yes, no cue required	66	73%	59	91%	19	48%	—	—
—	—	—	—	—	—	—	—	—	—
	QIVB6. Recalls Bed								
—	No, could not recall	23	26%	5	8%	14	35%	—	—
—	Yes, after cueing ("a piece of furniture")	12	13%	7	11%	11	28%	1	50%
—	Yes, no cue required	55	61%	53	82%	15	38%	1	50%
—	—	—	—	—	—	—	—	—	—
	QIVC1. Short Term Memory								
—	Memory OK	16	64%	22	73%	22	56%	—	—
—	Memory problem	9	36%	8	27%	17	44%	2	100%
—	Unable to assess	—	—	—	—	—	—	—	—
	QIVC2. Long Term Memory								
—	Memory OK	23	88%	19	73%	23	59%	—	—
—	Memory problem	3	12%	7	27%	16	41%	2	100%
—	Unable to assess	—	—	—	—	—	—	—	—
	QIVC3. Memory Recall Ability								
C3a	Current season	—	—	1	3%	1	2%	—	—
C3b	Location of own room	—	—	—	—	—	—	—	—
C3a, C3b	Current season AND Location of own room	1	4%	—	—	1	2%	1	50%
C3c	Staff names and faces	—	—	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
C3a, C3c	Current season AND Staff names and faces	—	—	2	6%	—	—	—	—
C3a, C3b, C3c	Current season AND Location of own room AND Staff names and faces	4	15%	—	—	—	—	—	—
C3d	That he or she is in a hospital (or nursing home or home)	2	8%	1	3%	7	16%	—	—
C3a, C3d	Current season AND That he or she is in a hospital (or nursing home or home)	—	—	1	3%	4	9%	—	—
C3a, C3b, C3d	Current season AND Location of own room AND That he or she is in a hospital (or nursing home or home)	—	—	—	—	3	7%	—	—
C3c, C3d	Staff names and faces AND That he or she is in a hospital (or nursing home or home)	2	8%	—	—	—	—	—	—
C3a, C3c, C3d	Current season AND Staff names and faces AND That he or she is in a hospital (or nursing home or home)	6	23%	—	—	4	9%	—	—
C3b, C3c, C3d	Location of own room AND Staff names and faces AND That he or she is in a hospital (or nursing home or homes)	—	—	—	—	1	2%	—	—
C3a, C3b, C3c, C3d	Current season AND Location of own room AND Staff names and faces AND That he or she is in a hospital (or nursing home or home)	9	35%	12	36%	11	26%	1	50%
C3e	None of the above are recalled or unable to assess	2	8%	16	48%	10	23%	—	—
C3a, C3b, C3e	Current season AND Location of own room AND None of the above are recalled or unable to assess	—	—	—	—	—	—	—	—
C3a, C3b, C3c, C3d, C3e	Current season AND Location of own room AND Staff names and faces AND That he or she is in a hospital (or nursing home or home) AND None of the above are recalled or unable to assess	—	—	—	—	1	2%	—	—
0	QIVC4. Daily Decisionmaking Independent: decisions consistently reasonable	13	59%	12	39%	18	44%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	Impaired: some difficulty or decisions								
1	poor; supervision required	7	32%	11	35%	20	49%	2	100%
9	Unable to assess	2	9%	8	26%	3	7%	—	—
—	***out of range***	—	—	—	—	—	—	—	—
	QIVD1. Inattention								
0	Behavior is not present	74	78%	74	81%	24	59%	1	50%
	Behavior continuously present, does not								
1	fluctuate.	9	9%	10	11%	4	10%	—	—
	Behavior present, fluctuates (comes and								
2	goes, changes in severity)	12	13%	7	8%	13	32%	1	50%
—	***out of range***	—	—	—	—	—	—	—	—
	QIVD2. Disorganized Thinking								
0	Behavior is not present	73	78%	79	86%	26	62%	1	50%
	Behavior continuously present, does not								
1	fluctuate.	9	10%	10	11%	2	5%	—	—
	Behavior present, fluctuates (comes and								
2	goes, changes in severity)	11	12%	3	3%	14	33%	1	50%
—	***out of range***	—	—	—	—	—	—	—	—
	QIVD3. Level of Alertness								
0	Behavior is not present	89	93%	85	92%	31	74%	2	100%
	Behavior continuously present, does not								
1	fluctuate.	4	4%	2	2%	—	—	—	—
	Behavior present, fluctuates (comes and								
2	goes, changes in severity)	3	3%	5	5%	11	26%	—	—
—	***out of range***	—	—	—	—	—	—	—	—
	QIVD4. Psychomotor Retardation								
0	Behavior is not present	90	94%	84	93%	29	69%	2	100%
	Behavior continuously present, does not								
1	fluctuate.	2	2%	4	4%	2	5%	—	—
	Behavior present, fluctuates (comes and								
2	goes, changes in severity)	4	4%	2	2%	11	26%	—	—
—	—	—	—	—	—	—	—	—	—
	QIVE1. Aggressive to Others								
0	No	94	100%	97	100%	43	100%	2	100%
1	Yes	—	—	—	—	—	—	—	—
—	***out of range***	—	—	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QIVE2. Verbally Abusive to Others								
0	No	91	98%	97	99%	42	98%	2	100%
1	Yes	2	2%	1	1%	1	2%	—	—
—	***out of range***	—	—	—	—	—	—	—	—
	QIVE3. Disruptive Behavior								
0	No	92	99%	94	99%	41	100%	2	100%
1	Yes	1	1%	1	1%	—	—	—	—
—	***out of range***	—	—	—	—	—	—	—	—
	QIVF1. Mood Interview Attempted								
0	No	20	22%	36	37%	13	33%	1	50%
1	Yes	71	78%	61	63%	27	68%	1	50%
—	***out of range***	—	—	—	—	—	—	—	—
	QIVF2A. No Pleasure								
0	No	55	71%	49	75%	18	55%	2	100%
1	Yes	20	26%	15	23%	9	27%	—	—
9	Unable to respond	3	4%	1	2%	6	18%	—	—
	QIVF2B. Days no interest								
0	not at all (0 to 1 days)	7	32%	4	21%	1	10%	—	—
1	several days (2 to 6 days)	11	50%	12	63%	7	70%	—	—
2	more than half of the days (7 to 11 days)	3	14%	3	16%	—	—	—	—
3	nearly every day (12 to 14 days)	1	5%	—	—	2	20%	—	—
—	***out of range***	—	—	—	—	—	—	—	—
	QIVF2C. Hopelessness								
0	No	50	64%	32	53%	15	44%	1	50%
1	Yes	27	35%	27	45%	14	41%	1	50%
9	Unable to respond	1	1%	1	2%	5	15%	—	—
	QIVF2D. Days Hopeless								
0	not at all (0 to 1 days)	3	10%	7	21%	—	—	—	—
1	several days (2 to 6 days)	22	73%	19	58%	11	79%	1	100%
2	more than half of the days (7 to 11 days)	2	7%	5	15%	1	7%	—	—
3	nearly every day (12 to 14 days)	3	10%	2	6%	2	14%	—	—
—	***out of range***	—	—	—	—	—	—	—	—
	QIVF3. Feeling Sad								
0	Never	36	44%	31	48%	11	32%	—	—
1	Rarely	14	17%	13	20%	3	9%	—	—
2	Sometimes	23	28%	15	23%	11	32%	1	100%
3	Often	4	5%	4	6%	2	6%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
4	Always	2	2%	1	2%	1	3%	—	—
9	Unable to respond	2	2%	1	2%	6	18%	—	—
	QIVG1. Fatigue Interview Attempted								
0	No	43	50%	59	61%	18	45%	1	50%
1	Yes	43	50%	37	39%	22	55%	1	50%
—	***out of range***	—	—	—	—	—	—	—	—
	QIVG2. Fatigue								
0	Never	21	40%	22	55%	6	24%	1	100%
1	Rarely	13	25%	11	28%	2	8%	—	—
2	Sometimes	12	23%	4	10%	5	20%	—	—
3	Often	5	9%	2	5%	4	16%	—	—
4	Always	1	2%	1	3%	1	4%	—	—
9	Unable to respond	1	2%	—	—	7	28%	—	—
	QIVH1. Pain Interview Attempted								
0	No	7	7%	17	18%	4	9%	—	—
1	Yes	89	93%	76	82%	40	91%	4	100%
—	***out of range***	—	—	—	—	—	—	—	—
	QIVH2. Pain Presence								
0	No	22	24%	24	30%	20	48%	3	75%
1	Yes	69	76%	56	70%	20	48%	1	25%
9	Unable to respond	—	—	—	—	2	5%	—	—
	QIVH3. Pain Severity VAS								
—	No pain	—	—	4	6%	3	13%	—	—
1	1	—	—	2	3%	—	—	—	—
—	2	2	3%	6	10%	—	—	—	—
—	3	5	7%	6	10%	1	4%	—	—
—	4	5	7%	8	13%	1	4%	—	—
—	5	16	23%	12	19%	2	8%	—	—
—	6	7	10%	7	11%	2	8%	—	—
—	7	7	10%	6	10%	—	—	—	—
—	8	6	9%	2	3%	4	17%	1	100%
—	9	9	13%	—	—	—	—	—	—
—	Worst pain you can imagine	6	9%	5	8%	5	21%	—	—
—	***out of range***	—	—	—	—	1	4%	—	—
—	patient does not answer or is unable to respond	6	9%	4	6%	5	21%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QIVH4. Pain Severity Likert								
1	Mild	10	15%	17	30%	2	8%	—	—
2	Moderate	34	51%	29	51%	8	33%	1	100%
3	Severe	17	25%	9	16%	5	21%	—	—
4	Very severe, horrible	5	7%	1	2%	4	17%	—	—
9	Unable to answer or no response	1	1%	1	2%	5	21%	—	—
	QIVH5A. Pain Hard to Sleep								
0	No	44	66%	43	78%	10	38%	1	100%
1	Yes	23	34%	12	22%	12	46%	—	—
9	Unable to answer or no response	—	—	—	—	4	15%	—	—
	QIVH5B. Pain Limits Activity								
0	No	38	58%	44	81%	6	23%	1	100%
1	Yes	26	40%	10	19%	15	58%	—	—
9	Unable to answer or no response	1	2%	—	—	5	19%	—	—
	QIVH6. Pain Observational Assessment								
G6a	Non-verbal sounds	—	—	—	—	—	—	—	—
G6b	Vocal complaints of pain	5	20%	6	43%	—	—	—	—
G6c	Facial Expressions	—	—	1	7%	1	4%	—	—
G6a, G6c	Non-verbal sounds AND Facial Expressions	—	—	—	—	—	—	—	—
G6b, G6c	Vocal complaints of pain AND Facial Expressions	—	—	1	7%	2	9%	—	—
G6a, G6b, G6c	Non-verbal sounds AND Vocal com-plaints of pain AND Facial expressions	—	—	—	—	—	—	—	—
G6d	Protective body movements or postures	—	—	—	—	4	17%	—	—
G6a, G6d	Non-verbal sounds AND Protective body movements or postures	—	—	—	—	—	—	—	—
G6a, G6b, G6d	Non-verbal sounds AND Vocal complaints of pain AND Protective body movements or postures	1	4%	—	—	—	—	—	—
G6d, G6c	Protective body movements or postures AND Facial expressions	—	—	—	—	6	26%	—	—
G6a, G6c, G6d	Non-verbal sounds AND Facial Expressions AND Protective body movements or postures	1	4%	—	—	—	—	—	—
G6b, G6c, G6d	Vocal complaints of pain AND Facial Expressions AND Protective body movements or postures	1	4%	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
G6a, G6b, G6c, G6d, G6e	Non-verbal sounds AND Vocal complaints of pain AND Facial Expressions AND Protective body movements or postures AND None	—	—	—	—	—	—	—	—
G6e	None	17	68%	6	43%	10	43%	—	—
	V. Impairments								
	QVA1A. Bladder Incontinence								
0	No	76	81%	84	86%	35	80%	3	75%
1	Yes	18	19%	14	14%	9	20%	1	25%
	QVA1B. Bowel Incontinence								
0	No	89	98%	96	99%	40	91%	4	100%
1	Yes	2	2%	1	1%	4	9%	—	—
	QVA2A. Bladder Incontinence Frequency								
0	Continent	70	80%	74	80%	21	48%	3	100%
1	Incontinent less than daily	6	7%	7	8%	2	5%	—	—
2	Incontinent daily	8	9%	10	11%	11	25%	—	—
3	Always incontinent	4	5%	1	1%	10	23%	—	—
4	No urine/bowel output during the last 2 days	—	—	—	—	—	—	—	—
	QVA2B. Bowel Incontinence Frequency								
0	Continent	78	83%	86	87%	23	52%	3	75%
1	Incontinent less than daily	5	5%	9	9%	5	11%	—	—
2	Incontinent daily	6	6%	4	4%	7	16%	1	25%
3	Always incontinent	3	3%	—	—	9	20%	—	—
4	No urine/bowel output during the last 2 days	2	2%	—	—	—	—	—	—
	QVA3A. Bladder								
0	No	49	52%	63	64%	17	39%	1	25%
1	Yes	45	48%	35	36%	27	61%	3	75%
	QVA3B. Bowel								
0	No	63	68%	75	77%	19	43%	2	50%
1	Yes	30	32%	22	23%	25	57%	2	50%
	QVB1. Swallowing Disorder Signs								
B1a	No sign or symptom of a possible swallowing disorder	74	78%	78	80%	32	73%	2	50%
B1b	Complaints of difficulty or pain with swallowing	3	3%	2	2%	8	18%	2	50%

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
B1c	Coughing or choking during meals or when swallowing medications	12	13%	11	11%	3	7%	—	—
—	—	—	—	—	—	—	—	—	—
B1d	Holding food in mouth/cheeks or residual food in mouth after meals	3	3%	7	7%	—	—	—	—
B1e	Loss of liquids/solids from mouth when eating or drinking	3	3%	—	—	—	—	—	—
B1f	***out of range***	—	—	—	—	1	2%	—	—
	QVB2. Usual ability to swallow								
1	Tube/parenteral feedings	3	3%	2	2%	3	7%	—	—
2	Modified food consistency/supervision	18	19%	17	18%	14	32%	4	100%
3	Regular food	73	78%	78	80%	27	61%	—	—
	QVC1. Comprehension								
1	Rarely/never understands	1	1%	1	1%	2	5%	—	—
2	Usually/sometimes understands	21	23%	24	25%	19	43%	2	50%
3	Understands	70	76%	72	74%	23	52%	2	50%
9	Unable to assess	—	—	—	—	—	—	—	—
	QVC2. Expression								
1	Rarely/Never expresses self or speech is very difficult to understand	1	1%	2	2%	1	2%	—	—
2	Exhibits difficulty with expressing needs and ideas or speech is not clear	30	32%	25	26%	12	27%	3	75%
3	Expresses complex messages without difficulty and with speech that is clear and easy to understand	62	67%	71	72%	30	68%	1	25%
9	Unable to assess	—	—	—	—	1	2%	—	—
	QVC3. Vision								
1	Severely Impaired	—	—	2	2%	2	5%	—	—
2	Mildly to Moderately Impaired	18	20%	14	14%	12	27%	1	25%
3	Adequate	72	78%	79	81%	29	66%	3	75%
9	Unable to assess	2	2%	2	2%	1	2%	—	—
	QVC4. Hearing								
1	Severely Impaired	1	1%	1	1%	—	—	—	—
2	Mildly to Moderately Impaired	20	21%	13	13%	6	14%	—	—
3	Adequate	73	78%	81	84%	37	84%	4	100%
9	Unable to assess	—	—	2	2%	1	2%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QVD1A. L Shoulder ROM								
0	Limited Range of Motion	19	20%	14	14%	6	14%	—	—
1	Within Normal Limits	76	80%	85	86%	36	86%	4	100%
	QVD1B. L Elbow ROM								
0	Limited Range of Motion	10	11%	7	7%	5	12%	—	—
1	Within Normal Limits	84	89%	91	93%	38	88%	4	100%
	QVD1C. R Shoulder ROM								
0	Limited Range of Motion	13	14%	10	10%	7	16%	1	25%
1	Within Normal Limits	82	86%	89	90%	36	84%	3	75%
	QVD1D. R Elbow ROM								
0	Limited Range of Motion	5	5%	5	5%	6	14%	1	25%
1	Within Normal Limits	88	95%	92	95%	37	86%	3	75%
	QVE1A. L UE Weightbearing								
0	Not fully weight-bearing	88	97%	92	97%	41	93%	3	75%
1	Fully weight-bearing:	3	3%	3	3%	3	7%	1	25%
	QVE1B. R UE Weightbearing								
0	Not fully weight-bearing	88	95%	95	97%	40	91%	3	75%
1	Fully weight-bearing:	5	5%	3	3%	4	9%	1	25%
	QVE1C. L LE Weightbearing								
0	Not fully weight-bearing	84	88%	93	95%	37	84%	2	50%
1	Fully weight-bearing:	11	12%	5	5%	7	16%	2	50%
	QVE1D. R LE Weightbearing								
0	Not fully weight-bearing	87	92%	91	94%	36	82%	2	50%
1	Fully weight-bearing:	8	8%	6	6%	8	18%	2	50%
	QVE1E. Buttocks								
0	Not fully weight-bearing	92	97%	97	100%	42	95%	2	50%
1	Fully weight-bearing:	3	3%	—	—	2	5%	2	50%
	QVF1. Shortness of Breath								
0	Never, patient was not short of breath	66	69%	85	86%	29	66%	1	25%
1	When climbing stairs	1	1%	—	—	—	—	—	—
2	With moderate exertion	14	15%	5	5%	7	16%	2	50%
3	With minimal exertion	9	9%	7	7%	2	5%	1	25%
4	At rest	2	2%	1	1%	—	—	—	—
9	Not assessed	4	4%	1	1%	6	14%	—	—
	QVG1. Stop to rest when walking								
0	No	48	51%	72	73%	9	21%	—	—
1	Yes	26	28%	15	15%	17	40%	3	75%
9	Not assessed	20	21%	11	11%	17	40%	1	25%

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	VI. Functional Status								
	QVIA1. Toilet Hygiene								
0	Not attempted, not finished, or not applicable	4	4%	1	1%	—	—	—	—
1	Dependent	22	23%	16	16%	9	23%	—	—
2	Substantial/Maximal Assistance	13	14%	1	1%	15	38%	—	—
3	Partial/Moderate Assistance	19	20%	7	7%	7	18%	2	100%
4	Supervision or Touching Assistance	35	37%	26	27%	5	13%	—	—
5	Setup or Clean-up Assistance	1	1%	21	21%	2	5%	—	—
6	Independent	—	—	26	27%	2	5%	—	—
	QVIA2. Oral Hygiene								
0	Not attempted, not finished, or not applicable	2	2%	1	1%	—	—	—	—
1	Dependent	1	1%	3	3%	2	5%	—	—
2	Substantial/Maximal Assistance	4	4%	1	1%	6	15%	—	—
3	Partial/Moderate Assistance	7	7%	—	—	7	17%	—	—
4	Supervision or Touching Assistance	20	21%	15	15%	10	24%	2	100%
5	Setup or Clean-up Assistance	59	62%	44	45%	8	20%	—	—
6	Independent	2	2%	34	35%	8	20%	—	—
	QVIA3. Eating								
0	Not attempted, not finished, or not applicable	8	9%	3	3%	1	2%	—	—
1	Dependent	—	—	2	2%	1	2%	—	—
2	Substantial/Maximal Assistance	3	3%	2	2%	5	12%	—	—
3	Partial/Moderate Assistance	4	4%	2	2%	6	15%	—	—
4	Supervision or Touching Assistance	9	10%	7	7%	5	12%	—	—
5	Setup or Clean-up Assistance	40	43%	23	23%	11	27%	2	100%
6	Independent	28	30%	59	60%	12	29%	—	—
	QVIA4. Tube Feeding								
0	Not attempted, not finished, or not applicable	44	81%	49	91%	24	80%	1	100%
1	Dependent	5	9%	3	6%	3	10%	—	—
2	Substantial/Maximal Assistance	—	—	—	—	2	7%	—	—
3	Partial/Moderate Assistance	—	—	—	—	1	3%	—	—
4	Supervision or Touching Assistance	2	4%	—	—	—	—	—	—
5	Setup or Clean-up Assistance	2	4%	1	2%	—	—	—	—
6	Independent	1	2%	1	2%	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QVIB1. Walk 50 ft								
0	Not attempted, not finished, or not applicable	8	12%	5	6%	19	54%	1	100%
1	Dependent	14	21%	8	9%	2	6%	—	—
2	Substantial/Maximal Assistance	—	—	1	1%	2	6%	—	—
3	Partial/Moderate Assistance	9	13%	2	2%	5	14%	—	—
4	Supervision or Touching Assistance	36	53%	29	32%	5	14%	—	—
5	Setup or Clean-up Assistance	1	1%	15	17%	—	—	—	—
6	Independent	—	—	30	33%	2	6%	—	—
	QVIB2. Walk in Room Once Standing								
0	Not attempted, not finished, or not applicable	7	9%	5	5%	13	35%	—	—
1	Dependent	4	5%	4	4%	2	5%	—	—
2	Substantial/Maximal Assistance	3	4%	2	2%	5	14%	—	—
3	Partial/Moderate Assistance	12	16%	6	7%	12	32%	2	100%
4	Supervision or Touching Assistance	49	64%	33	36%	3	8%	—	—
5	Setup or Clean-up Assistance	2	3%	11	12%	—	—	—	—
6	Independent	—	—	31	34%	2	5%	—	—
	QVIB3. Toilet Transfer								
0	Not attempted, not finished, or not applicable	3	3%	4	4%	2	5%	—	—
1	Dependent	11	13%	6	6%	8	20%	—	—
2	Substantial/Maximal Assistance	8	9%	4	4%	15	38%	—	—
3	Partial/Moderate Assistance	30	34%	6	6%	9	23%	2	100%
4	Supervision or Touching Assistance	32	37%	34	35%	3	8%	—	—
5	Setup or Clean-up Assistance	3	3%	11	11%	1	3%	—	—
6	Independent	—	—	31	32%	2	5%	—	—
	QVIB4. Chair/Bed-to-Chair Transfer								
0	Not attempted, not finished, or not applicable	—	—	3	3%	—	—	—	—
1	Dependent	7	8%	5	5%	10	24%	—	—
2	Substantial/Maximal Assistance	13	14%	4	4%	14	34%	—	—
3	Partial/Moderate Assistance	28	30%	5	5%	11	27%	2	100%
4	Supervision or Touching Assistance	43	46%	30	31%	4	10%	—	—
5	Setup or Clean-up Assistance	2	2%	11	11%	1	2%	—	—
6	Independent	—	—	39	40%	1	2%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QVIB5. Sit to Stand								
0	Not attempted, not finished, or not applicable	2	2%	—	—	4	10%	—	—
1	Dependent	4	4%	4	4%	4	10%	—	—
2	Substantial/Maximal Assistance	11	12%	9	9%	14	36%	—	—
3	Partial/Moderate Assistance	28	31%	2	2%	11	28%	2	100%
4	Supervision or Touching Assistance	42	47%	27	28%	4	10%	—	—
5	Setup or Clean-up Assistance	3	3%	15	16%	1	3%	—	—
6	Independent	—	—	39	41%	1	3%	—	—
	QVIB6. Lying to Sitting on Side of Bed								
0	Not attempted, not finished, or not applicable	2	2%	1	1%	—	—	—	—
1	Dependent	3	3%	2	2%	5	12%	—	—
2	Substantial/Maximal Assistance	17	18%	6	6%	17	41%	—	—
3	Partial/Moderate Assistance	36	39%	8	8%	10	24%	—	—
4	Supervision or Touching Assistance	19	20%	14	15%	4	10%	1	50%
5	Setup or Clean-up Assistance	13	14%	18	19%	2	5%	—	—
6	Independent	3	3%	47	49%	3	7%	1	50%
	QVIB7. Use Wheelchair?								
0	No	66	73%	81	84%	10	24%	—	—
1	Yes	25	27%	15	16%	31	76%	2	100%
	QVIB8. Wheel 50 ft - Interior								
0	Not attempted, please specify below	4	19%	—	—	8	30%	—	—
1	Dependent	4	19%	2	11%	7	26%	2	100%
2	Substantial/Maximal Assistance	1	5%	2	11%	6	22%	—	—
3	Partial/Moderate Assistance	3	14%	—	—	3	11%	—	—
4	Supervision or Touching Assistance	7	33%	7	39%	—	—	—	—
5	Setup or Clean-up Assistance	1	5%	2	11%	1	4%	—	—
6	Independent	1	5%	5	28%	2	7%	—	—
	QVIB9. Wheel in Room Once Seated								
0	Not attempted, please specify below	4	15%	—	—	6	21%	—	—
1	Dependent	4	15%	3	18%	5	17%	—	—
2	Substantial/Maximal Assistance	1	4%	2	12%	4	14%	—	—
3	Partial/Moderate Assistance	4	15%	1	6%	10	34%	2	100%
4	Supervision or Touching Assistance	7	27%	5	29%	—	—	—	—
5	Setup or Clean-up Assistance	5	19%	2	12%	1	3%	—	—
6	Independent	1	4%	4	24%	3	10%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QVIC1. Sponge Bath								
0	Not attempted, please specify below	1	3%	—	—	—	—	—	—
1	Dependent	4	12%	4	29%	2	50%	—	—
2	Substantial/Maximal Assistance	9	27%	2	14%	2	50%	—	—
3	Partial/Moderate Assistance	16	48%	1	7%	—	—	—	—
4	Supervision or Touching Assistance	2	6%	2	14%	—	—	—	—
5	Setup or Clean-up Assistance	1	3%	2	14%	—	—	—	—
6	Independent	—	—	3	21%	—	—	—	—
	QVIC2. Sit to Lying								
0	Not attempted, please specify below	1	3%	—	—	—	—	—	—
1	Dependent	2	6%	5	45%	1	25%	—	—
2	Substantial/Maximal Assistance	14	42%	2	18%	3	75%	—	—
3	Partial/Moderate Assistance	9	27%	—	—	—	—	—	—
4	Supervision or Touching Assistance	4	12%	1	9%	—	—	—	—
5	Setup or Clean-up Assistance	2	6%	2	18%	—	—	—	—
6	Independent	1	3%	1	9%	—	—	—	—
	QVIC3. Roll left or right								
0	Not attempted, please specify below	3	10%	—	—	—	—	—	—
1	Dependent	3	10%	3	38%	1	25%	—	—
2	Substantial/Maximal Assistance	9	31%	3	38%	3	75%	—	—
3	Partial/Moderate Assistance	4	14%	—	—	—	—	—	—
4	Supervision or Touching Assistance	7	24%	1	13%	—	—	—	—
5	Setup or Clean-up Assistance	1	3%	—	—	—	—	—	—
6	Independent	2	7%	1	13%	—	—	—	—
—	***out of range***	—	—	—	—	—	—	—	—
	QVID1. Upper Body Dressing								
0	Not attempted, please specify below	2	4%	—	—	—	—	—	—
1	Dependent	1	2%	1	4%	7	24%	—	—
2	Substantial/Maximal Assistance	9	16%	2	7%	9	31%	2	100%
3	Partial/Moderate Assistance	13	24%	2	7%	8	28%	—	—
4	Supervision or Touching Assistance	11	20%	9	33%	1	3%	—	—
5	Setup or Clean-up Assistance	18	33%	6	22%	1	3%	—	—
6	Independent	1	2%	7	26%	3	10%	—	—
	QVID2. Shower/Bathe Self								
0	Not attempted, please specify below	5	10%	—	—	—	—	—	—
1	Dependent	4	8%	2	7%	6	21%	—	—
2	Substantial/Maximal Assistance	14	29%	8	29%	14	48%	—	—
3	Partial/Moderate Assistance	14	29%	6	21%	8	28%	2	100%

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
4	Supervision or Touching Assistance	10	21%	5	18%	1	3%	—	—
5	Setup or Clean-up Assistance	1	2%	1	4%	—	—	—	—
6	Independent	—	—	6	21%	—	—	—	—
	QVID3. Picking up								
0	Not attempted, please specify below	24	63%	11	55%	16	62%	—	—
1	Dependent	1	3%	—	—	6	23%	—	—
2	Substantial/Maximal Assistance	—	—	—	—	1	4%	—	—
3	Partial/Moderate Assistance	—	—	—	—	1	4%	2	100%
4	Supervision or Touching Assistance	2	5%	2	10%	—	—	—	—
5	Setup or Clean-up Assistance	11	29%	7	35%	2	8%	—	—
6	Independent	—	—	—	—	—	—	—	—
	QVID4. I step (curb)								
0	Not attempted, please specify below	20	51%	9	47%	19	73%	—	—
1	Dependent	—	—	2	11%	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—	1	4%	—	—
3	Partial/Moderate Assistance	3	8%	3	16%	2	8%	2	100%
4	Supervision or Touching Assistance	5	13%	2	11%	2	8%	—	—
5	Setup or Clean-up Assistance	11	28%	3	16%	2	8%	—	—
6	Independent	—	—	—	—	—	—	—	—
	QVID5. Short ramp								
0	Not attempted, please specify below	6	86%	3	50%	15	71%	—	—
1	Dependent	1	14%	1	17%	5	24%	2	100%
2	Substantial/Maximal Assistance	—	—	—	—	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—	—	—	—	—
5	Setup or Clean-up Assistance	—	—	2	33%	—	—	—	—
6	Independent	—	—	—	—	1	5%	—	—
	QVIE1. Lower Body dressing								
0	Not attempted, please specify below	1	4%	2	4%	—	—	—	—
1	Dependent	4	15%	1	2%	—	—	—	—
2	Substantial/Maximal Assistance	7	26%	2	4%	2	33%	—	—
3	Partial/Moderate Assistance	5	19%	11	19%	1	17%	—	—
4	Supervision or Touching Assistance	8	30%	20	35%	2	33%	—	—
5	Setup or Clean-up Assistance	—	—	9	16%	1	17%	—	—
6	Independent	2	7%	12	21%	—	—	—	—
	QVIE2. 12 steps-interior								
0	Not attempted, please specify below	12	86%	12	31%	3	50%	—	—
1	Dependent	—	—	2	5%	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
2	Substantial/Maximal Assistance	—	—	—	—	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—	1	17%	—	—
4	Supervision or Touching Assistance	—	—	12	31%	1	17%	—	—
5	Setup or Clean-up Assistance	2	14%	7	18%	1	17%	—	—
6	Independent	—	—	6	15%	—	—	—	—
	QVIE3. 4 steps-exterior								
0	Not attempted, please specify below	8	44%	7	13%	3	50%	—	—
1	Dependent	—	—	—	—	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—	—	—	—	—
3	Partial/Moderate Assistance	1	6%	4	8%	—	—	—	—
4	Supervision or Touching Assistance	8	44%	22	42%	2	33%	—	—
5	Setup or Clean-up Assistance	1	6%	9	17%	1	17%	—	—
6	Independent	—	—	10	19%	—	—	—	—
	QVIE4. Walk longer distances-interior								
0	Not attempted, please specify below	5	25%	1	2%	1	17%	—	—
1	Dependent	—	—	—	—	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—	1	17%	—	—
3	Partial/Moderate Assistance	1	5%	1	2%	1	17%	—	—
4	Supervision or Touching Assistance	13	65%	18	38%	1	17%	—	—
5	Setup or Clean-up Assistance	1	5%	8	17%	1	17%	—	—
6	Independent	—	—	20	42%	1	17%	—	—
	QVIE5. Wheel longer distances-interior								
0	Not attempted, please specify below	4	80%	—	—	2	50%	—	—
1	Dependent	—	—	—	—	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—	—	—	—	—
4	Supervision or Touching Assistance	—	—	3	50%	1	25%	—	—
5	Setup or Clean-up Assistance	1	20%	—	—	1	25%	—	—
6	Independent	—	—	3	50%	—	—	—	—
	QVIE6. Long ramp-exterior								
0	Not attempted, please specify below	5	100%	—	—	4	100%	—	—
1	Dependent	—	—	—	—	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—	—	—	—	—
5	Setup or Clean-up Assistance	—	—	—	—	—	—	—	—
6	Independent	—	—	3	100%	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QVIF1. Laundry								
0	Not attempted, please specify below	4	80%	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	1	20%	1	33%	1	100%	—	—
4	Independent	—	—	2	67%	—	—	—	—
	QVIF2. Make light meal								
0	Not attempted, please specify below	4	80%	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	1	20%	1	100%	—	—
4	Independent	1	20%	4	80%	—	—	—	—
	QVIF3. Dishwashing-By Hand								
0	Not attempted, please specify below	4	80%	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	—	—	1	100%	—	—
4	Independent	1	20%	4	100%	—	—	—	—
—	***out of range***	—	—	—	—	—	—	—	—
	QVIF4. Dishwashing-Machine								
0	Not attempted, please specify below	4	80%	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	—	—	1	100%	—	—
4	Independent	1	20%	3	100%	—	—	—	—
	QVIF5. Wipe down surface								
0	Not attempted, please specify below	4	80%	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	—	—	—	—	—	—
4	Independent	1	20%	4	100%	1	100%	—	—
	QVIF6. Telephone-Answering								
0	Not attempted, please specify below	2	25%	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	1	13%	—	—	1	100%	—	—
4	Independent	3	38%	4	100%	—	—	—	—
—	***out of range***	2	25%	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QVIF7. Telephone-Placing Call								
0	Not attempted, please specify below	2	25%	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	—	—	—	—	—	—
4	Independent	6	75%	4	100%	1	100%	—	—
	QVIF8. Medication Management - Oral Medications								
0	Not attempted, please specify below	2	40%	—	—	—	—	—	—
1	Dependent (Total Assistance)	1	20%	—	—	—	—	—	—
2	Maximum Assistance	1	20%	—	—	—	—	—	—
3	Minimal Assistance	—	—	1	25%	—	—	—	—
4	Independent	1	20%	3	75%	1	100%	—	—
—	***out of range***	—	—	—	—	—	—	—	—
	QVIF9. Medication Management-Inhalation/Mist Medications								
0	Not attempted, please specify below	4	80%	1	100%	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	1	20%	—	—	—	—	—	—
3	Minimal Assistance	—	—	—	—	1	100%	—	—
4	Independent	—	—	—	—	—	—	—	—
—	***outside correct range***	—	—	—	—	—	—	—	—
	QVIF10. Medication Management-Injectable Medications								
0	Not attempted, please specify below	5	100%	1	100%	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	1	100%	—	—
3	Minimal Assistance	—	—	—	—	—	—	—	—
4	Independent	—	—	—	—	—	—	—	—
	QVIG1. Get in/out of car								
0	Not attempted, please specify below	—	—	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	1	20%	—	—	—	—
4	Independent	—	—	4	80%	—	—	—	—
	QVIG2. Light shopping								
0	Not attempted, please specify below	—	—	1	20%	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	1	20%	—	—	—	—
4	Independent	—	—	3	60%	—	—	—	—
	QVIG3. Walk a block								
0	Not attempted, please specify below	—	—	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	1	20%	—	—	—	—
4	Independent	—	—	4	80%	—	—	—	—
—	outside correct range	—	—	—	—	—	—	—	—
	QVIG4. Use Public Transportation								
0	Not attempted, please specify below	—	—	1	100%	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	—	—	—	—	—	—
4	Independent	—	—	—	—	—	—	—	—
	QVIG5. Drive a car								
0	Not attempted, please specify below	—	—	1	100%	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	—	—	—	—	—	—
4	Independent	—	—	—	—	—	—	—	—
	QVIG6. Wheel a block								
0	Not attempted, please specify below	—	—	—	—	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—	—	—	—	—
2	Maximum Assistance	—	—	—	—	—	—	—	—
3	Minimal Assistance	—	—	—	—	—	—	—	—
4	Independent	—	—	—	—	—	—	—	—
	QVIH1. Surprised at patient readmittance to hospital in next 3-6 months?								
0	No	55	59%	47	48%	28	65%	1	100%
1	Yes	38	41%	47	48%	8	19%	—	—
9	Not assessed/don't know	—	—	4	4%	7	16%	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QVIH2. Surprised if patient dies in next 6-12 months?								
0	No	12	13%	16	16%	7	16%	—	—
1	Yes	80	86%	78	80%	25	58%	1	100%
9	Not assessed/don't know	1	1%	4	4%	11	26%	—	—
	VII. Discharge Status								
	QVIIB1. Discharge location								
1	Private residence	—	—	66	68%	—	—	1	50%
2	Other community-based residence setting	—	—	2	2%	—	—	—	—
3	Long-term care facility/nursing home	—	—	1	1%	—	—	—	—
4	Skilled nursing facility	—	—	17	18%	—	—	—	—
5	Inpatient rehabilitation hospital or unit	—	—	—	—	—	—	—	—
6	Long-term care hospital	—	—	—	—	—	—	—	—
7	Short-stay acute hospital	—	—	6	6%	—	—	1	50%
8	Hospice care	—	—	—	—	—	—	—	—
9	Psychiatric Hospital or unit	—	—	—	—	—	—	—	—
10	Other	—	—	5	5%	—	—	—	—
11	Discharged against medical advice	—	—	—	—	—	—	—	—
12	Expired	—	—	—	—	—	—	—	—
	QVIIB2. Structural Barrier								
B2a	Structural barriers are not an issue.	—	—	32	35%	—	—	2	100%
B2b	Stairs inside the living setting that must be used by patient (e.g., to get to toileting, sleeping, eating areas).	—	—	11	12%	—	—	—	—
B2c	Stairs leading from inside to outside of living setting.	—	—	18	20%	—	—	—	—
B2b, B2c	Stairs inside the living setting that must be used by patient (e.g., to get to toileting, sleeping, eating areas) AND Stairs leading from inside to outside of living setting.	—	—	28	31%	—	—	—	—
B2d	Narrow or obstructed doorways	—	—	—	—	—	—	—	—
B2c, B2d	Stairs leading from inside to outside of living setting AND Narrow or obstructed doorways for patients using wheelchairs or walkers.	—	—	2	2%	—	—	—	—
B2e	Insufficient space to accommodate extra equipment (e.g. hospital bed, vent equipment)	—	—	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
B2b, B2c, B2d, B2e	Stairs inside the living setting that must be used by patient AND Stairs leading from inside to outside AND Narrow or obstructed doorways AND Insufficient space to accommodate extra equipment (e.g. hospital bed, vent equipment)	—	—	—	—	—	—	—	—
	QVIIC1. Live With on Discharge								
C1a	Will live Alone	—	—	14	20%	—	—	—	—
C1b	Spouse or Significant other.	—	—	26	37%	—	—	—	—
C1c	Adult child (> 18 years).	—	—	13	19%	—	—	1	100%
C1b, C1c	Spouse or Significant other AND Adult child (> 18 years).	—	—	5	7%	—	—	—	—
C1d	Other unpaid family member or friend.	—	—	2	3%	—	—	—	—
C1a, C1d	Will live Alone AND Other unpaid family member or friend.	—	—	—	—	—	—	—	—
C1b, C1d	Spouse or Significant other AND Other unpaid family member or friend.	—	—	1	1%	—	—	—	—
C1c, C1d	Adult child (>18 years) AND Other unpaid family member or friend.	—	—	1	1%	—	—	—	—
C1e	Paid help, other than home care agency.	—	—	6	9%	—	—	—	—
C1a, C1e	Will live Alone AND Paid help other than home care agency	—	—	—	—	—	—	—	—
C1b, C1e	Spouse or Significant other AND Paid help, other than home care agency	—	—	2	3%	—	—	—	—
C1d, C1e	Other unpaid family member or friend AND Paid help other than home care agency	—	—	—	—	—	—	—	—
	QVIIC2. Frequency of Assistance								
1	Does not require assistance	—	—	4	5%	—	—	—	—
2	Weekly or less	—	—	14	18%	—	—	—	—
3	Less than daily but more often than weekly	—	—	6	8%	—	—	—	—
4	Intermittently during the day or night	—	—	33	43%	—	—	—	—
5	All night but not during the day	—	—	—	—	—	—	—	—
6	All day but not at night	—	—	1	1%	—	—	—	—
7	24 hours per day	—	—	19	25%	—	—	1	100%

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	QVIIC3. Caregiver Availability								
0	No	—	—	9	12%	—	—	—	—
1	Yes	—	—	67	88%	—	—	1	100%
	QVIIC4. Type of Caregiver								
C4a	Spouse or Significant other.	—	—	28	39%	—	—	—	—
C4b	Adult child (> 18 years).	—	—	22	31%	—	—	—	—
C4a, C4b	Spouse or Significant other AND Adult child (>18 years)	—	—	4	6%	—	—	—	—
C4c	Other unpaid family member or friend.	—	—	4	6%	—	—	—	—
C4a, C4c	Spouse or Significant other AND Other unpaid family member or friend.	—	—	1	1%	—	—	—	—
C4b, C4c	Adult child (> 18 years) AND Other unpaid family member or friend	—	—	3	4%	—	—	1	100%
C4d	Paid help, other than home care agency.	—	—	8	11%	—	—	—	—
C4a, C4d	Spouse or Significant other AND Paid help, other than home care agency	—	—	1	1%	—	—	—	—
C4c, C4d	Other unpaid family member or friend AND Paid help, other than home care agency	—	—	—	—	—	—	—	—
	QVIIC5A. Able to pay for meds								
0	Unable to assess	—	—	4	5%	—	—	—	—
1	No	—	—	6	7%	—	—	—	—
2	Yes	—	—	48	59%	—	—	2	100%
3	Unknown	—	—	23	28%	—	—	—	—
	QVIIC5B. Transport to clinic								
0	Unable to assess	—	—	1	1%	—	—	—	—
1	No follow up physician appointments and/or outpatient therapies or treatments planned	—	—	—	—	—	—	—	—
2	Can drive self	—	—	2	3%	—	—	—	—
3	Family member or friend will drive patient	—	—	61	81%	—	—	2	100%
4	Public transportation	—	—	—	—	—	—	—	—
5	Other	—	—	11	15%	—	—	—	—
	QVIID1. HHA PAC								
1	Deemed Appropriate by the Provider.	—	—	47	100%	—	—	1	100%
2	Bed Available.	—	—	—	—	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—	—	—	—	—

(continued)

Table E-1b (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
IRFand SNF

Code	Value Choices	IRF Admission Respondents to Question	IRF Admission % Distribution	IRF Discharge Respondents to Question	IRF Discharge % Distribution	SNF Admission Respondents to Question	SNF Admission % Distribution	SNF Discharge Respondents to Question	SNF Discharge % Distribution
	AVIID2. SNF PAC								
1	Deemed Appropriate by the Provider.	—	—	11	92%	—	—	—	—
2	Bed Available.	—	—	1	8%	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—	—	—	1	100%
	QVIID3. IRF PAC								
1	Deemed Appropriate by the Provider.	—	—	—	—	—	—	—	—
2	Bed Available.	—	—	—	—	—	—	—	—
4	Refused by Patient/Family.	—	—	1	100%	—	—	—	—
	QVIID4. LTCH PAC								
1	Deemed Appropriate by the Provider.	—	—	2	67%	—	—	—	—
2	Bed Available.	—	—	—	—	—	—	—	—
4	Refused by Patient/Family.	—	—	1	33%	—	—	—	—
	QVIID5. PSYCH PAC								
1	Deemed Appropriate by the Provider.	—	—	—	—	—	—	—	—
2	Bed Available.	—	—	—	—	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—	—	—	—	—
	QVIID6. OTHER PAC								
1	Deemed Appropriate by the Provider.	—	—	24	96%	—	—	—	—
2	Bed Available.	—	—	1	4%	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—	—	—	—	—
	QVIID7B. Discharge Provider Type								
—	HHA	—	—	3	6%	—	—	—	—
—	SNF	—	—	1	2%	—	—	—	—
—	IRF	—	—	16	32%	—	—	1	100%
—	LTCH	—	—	30	60%	—	—	—	—
	QVIIE1. Patient discharge delayed								
0	No	—	—	82	88%	—	—	1	100%
1	Yes	—	—	11	12%	—	—	—	—
	QVIIE2. Reason for Discharge Delay								
1	No bed available	—	—	—	—	—	—	—	—
2	Services, equipment or medications not available	—	—	1	9%	—	—	—	—
3	Family/support	—	—	2	18%	—	—	—	—
4	Medical	—	—	4	36%	—	—	—	—
5	Other	—	—	4	36%	—	—	—	—

Table E-1c
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	I. Administrative Items				
	QIA8. Gender				
1	Male	12	43%	4	50%
2	Female	16	57%	4	50%
	QIA9. Ethnicity				
1	American Indian or Alaska Native	—	—	—	—
2	Asian	—	—	—	—
3	Black or African American	2	7%	1	13%
4	Hispanic or Latino	3	11%	—	—
5	Native Hawaiian or Pacific Islander	1	4%	—	—
6	White	21	75%	7	88%
2, 6	White and Asian	—	—	—	—
7	Unknown	1	4%	—	—
	QIA10. Educational Level				
1	Less than 1 year of high school	5	20%	—	—
2	High School Graduate or GED	8	32%	2	33%
3	Some college	7	28%	1	17%
4	Four-year college degree	4	16%	2	33%
5	More than 4 years of college	1	4%	1	17%
	QIA11. Advanced Directive				
0	No	19	70%	4	50%
1	Yes	8	30%	4	50%
	QIA12. Durable Power of Attorney				
0	No	18	67%	4	57%
1	Yes	9	33%	3	43%
	QIA13. Code Status Documented				
0	No	20	77%	6	75%
1	Yes	6	23%	2	25%
B1a	Q1B1. Current Payment Source	—	—	—	—
B1b	Medicare (traditional fee-for-service)	29	100%	—	—
B1c	Medicare (HMO/Managed Care)	—	—	—	—
B1d	Medicaid (traditional fee-for-service)	—	—	—	—
B1d, B1b	Medicaid (traditional fee-for-service) AND Medicare (traditional fee-for-service)	—	—	—	—
B1e	Medicaid (HMO/Managed care)	—	—	—	—
B1e, B1b	Medicaid (HMO/Managed care) AND Medicare (traditional fee-for-service)	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
B1f	Workers' compensation	—	—	—	—
B1g	Title programs (e.g., Title III, V, or XX)	—	—	—	—
B1h	Other government (e.g., CHAMPUS, VA, etc.)	—	—	—	—
B1i	Private insurance	—	—	—	—
B1i, B1d	Private insurance AND Medicare (traditional fee-for-service)	—	—	—	—
B1i, B1c	Private insurance AND Medicare (HMO/Managed care)	—	—	—	—
B1i, B1d	Private insurance AND Medicaid (traditional fee-for-service)	—	—	—	—
B1j, B1b	Private HMO/managed care AND Medicare (traditional fee-for-service)	—	—	—	—
B1k, B1d, B1b	Self-pay AND Medicaid (traditional fee-for-service) AND Medicare (traditional fee-for-service)	—	—	—	—
B1l	Other	—	—	—	—
B1l, B1b	Other AND Medicare (traditional fee-for-service)	—	—	—	—
B1l, B1c	Other AND Medicare (HMO/managed care)	—	—	—	—
B1l, B1d	Other AND Medicaid (traditional fee-for-service)	—	—	—	—
B1m	Unknown	—	—	—	—
	II. Admission Information				
	QIIA2. Admitted From				
1	Private residence	11	38%	—	—
2	Community-based residence (e.g., assisted living residence, group home, adult foster care)	2	7%	—	—
3	Long-term care facility/nursing home	—	—	—	—
4	Skilled nursing facility (includes subacute) (SNF/TCU)	—	—	—	—
5	Short-stay acute hospital. (IPPS)	13	45%	—	—
6	Long-term care hospital. (LTCH)	1	3%	—	—
7	Inpatient rehabilitation hospital or unit	2	7%	—	—
8	Psychiatric Hospital or unit	—	—	—	—
9	Hospice	—	—	—	—
10	Other	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QIIA4. Prior Services				
A4a	Skilled nursing facility (includes subacute)	1	25%	—	—
A4b	Inpatient rehabilitation hospital or unit	—	—	—	—
A4c	Long-term care hospital	—	—	—	—
A4d	Psychiatric Hospital or unit	—	—	—	—
A4a, A4b, A4c	Skilled nursing facility (includes subacute) AND inpatient rehabilitation hospital or unit AND and long-term care hospital	—	—	—	—
A4e	Acute short admission hospital	1	25%	—	—
A4a, A4e	Skilled nursing facility (includes subacute) AND acute short admission hospital	1	25%	—	—
A4a, A4b, A4c, A4e	Skilled nursing faciltiy (includes subacute) AND inpatient rehabilitation hospital or unit AND long-term care hospital AND acute short admission hospital	—	—	—	—
A4f	Home health	1	25%	—	—
A4a, A4f	Skilled nursing facility (includes subacute) AND Home health	—	—	—	—
A4b, A4f	Inpatient rehabilitation hospital or unit AND Home health	—	—	—	—
A4e, A4f	Acute short admission hospital AND Home health	—	—	—	—
A4a, A4e, A4f	Skilled nursing facility (includes subacute) AND acute short admission hospital AND home health	—	—	—	—
	QIIA5. Prior Residence				
1	Private residence	23	82%	—	—
2	Community-based residence	5	18%	—	—
3	Permanently in a long-term care facility	—	—	—	—
4	Other	—	—	—	—
	QIIA7. Lives with				
A7a	Lives Alone	9	32%	—	—
A7b	Spouse or Significant other	11	39%	—	—
A7c	Adult child (> 18 years)	4	14%	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
A7b, A7c	Spouse or Significant other AND Adult child (> 18 years)	1	4%	—	—
A7d	Other unpaid family member or friend	—	—	—	—
A7c, A7d	Adult child (> 18 years) AND Other unpaid family member or friend	—	—	—	—
A7e	Paid help living in the home (other than home care)	3	11%	—	—
A7b, A7e	Spouse or Significant other AND Paid help living in the home (other than home care)	—	—	—	—
A7d, A7e	Other unpaid family member or friend AND Paid help living in the home (other than home care)	—	—	—	—
	QIIA8A. Prior Function Self Care				
3	Independent	16	55%	—	—
2	Needed Some Help	11	38%	—	—
1	Dependent	2	7%	—	—
9	Not applicable	—	—	—	—
	QIIA8B. Prior Function Mobility				
3	Independent	15	52%	—	—
2	Needed Some Help	10	34%	—	—
1	Dependent	2	7%	—	—
9	Not applicable	2	7%	—	—
	QIIA8C. Prior Function Cognition				
3	Independent	16	55%	—	—
2	Needed Some Help	5	17%	—	—
1	Dependent	8	28%	—	—
9	Not applicable	—	—	—	—
	QIIA9. Change in mental status				
0	No	28	97%	—	—
1	Yes	1	3%	—	—
9	Unknown	—	—	—	—
	QIIA10. History of Incontinence				
0	No	17	59%	—	—
1	Bladder only	7	24%	—	—
2	Bowel only	—	—	—	—
3	Bladder and bowel	5	17%	—	—
9	Unknown	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	III. Current Medical Items				
	QIIIC1. Diagnostic Procedures during Admission?				
0	No	1	100%	2	100%
1	Yes	—	—	—	—
	QIIID1. None				
1	At Discharge	20	87%	3	43%
2	Anytime during stay	3	13%	4	57%
	QIIID2. Insulin Drip				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	1	100%
	QIIID3. Total Parenteral Nutrition				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID4. Central Line Management				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID5. Blood Transfusion(s)				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID6. Controlled Parenteral Analgesia - Peripheral				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID7. Controlled Parenteral Analgesia - Epidural				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID8. Left Ventricular Assistive Device (LVAD)				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID9. Continuous Cardiac Monitoring				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID10. Chest Tube(s)				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QIIID11. ET Tube Care and Management				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID12. Trach Tube with Suctioning:				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID13. High O2 Concentration Delivery System with Fi)2 > 40%				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID14. Ventilator - Weaning				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID15. ventilator - Non-Weaning				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID16. Hemodialysis				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID18. Peritoneal Dialysis				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID19. Fistula or Other Drain Management				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID20. Negative Pressure Wound Therapy				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID23. One-on-one 24-Hour Supervision				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—
	QIIID24. Specialty Bed				
1	At Discharge	—	—	—	—
2	Anytime during stay	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QIIIF1. Allergy Status				
0	No known	—	—	2	50%
1	Yes	—	—	2	50%
	QIIIG1A. Pressure Ulcer Risk Assessment				
0	No	6	23%	—	—
1	Yes, it indicated not high risk	18	69%	7	88%
2	Yes, it indicated high risk	2	8%	1	13%
	QIIIG1B. Presence of Pressure Ulcer				
0	No	24	92%	8	100%
1	Yes	2	8%	—	—
	QIIIG2A. Unhealed Pressure Ulcer Stg2				
0	No unhealed ulcers at this stage	1	50%	1	100%
1	One unhealed ulcer at this stage	1	50%	—	—
2	Two unhealed ulcers at this stage	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—
	QIIIG2B. Stg2 Pressure Ulcers found this admission				
0	No unhealed ulcers at this stage	—	—	—	—
1	One unhealed ulcer at this stage	—	—	1	100%
2	Two unhealed ulcers at this stage	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—
	QIIIG2C. Unhealed Pressure Ulcers Stg3				
0	No unhealed ulcers at this stage	3	100%	—	—
1	One unhealed ulcer at this stage	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—
	QIIIG2D. Stg3 Pressure Ulcers found this admission				
0	No unhealed ulcers at this stage	—	—	—	—
1	One unhealed ulcer at this stage	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
3	Three unhealed ulcers at this stage	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—
	QIIIG2E. Unhealed Pressure Ulcers Stg4				
0	No unhealed ulcers at this stage	3	100%	—	—
1	One unhealed ulcer at this stage	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—
	QIIIG2F. Stg4 Pressure Ulcers found this admission				
0	No unhealed ulcers at this stage	—	—	—	—
1	One unhealed ulcer at this stage	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—
	QIIIG2G. Unhealed Pressure Ulcers unstageable				
0	No unhealed ulcers at this stage	3	100%	—	—
1	One unhealed ulcer at this stage	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—
	QIIIG2H. Unstageable Pressure Ulcers found this admission				
0	No unhealed ulcers at this stage	—	—	—	—
1	One unhealed ulcer at this stage	—	—	—	—
2	Two unhealed ulcers at this stage	—	—	—	—
3	Three unhealed ulcers at this stage	—	—	—	—
4	Four or more unhealed ulcers at this stage	—	—	—	—
	QIIIG5. Ulcers with Tunneling				
0	No	2	100%	—	—
1	Yes	—	—	—	—
9	Unable to assess	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QIIIG6. Major wound present				
0	No	13	72%	4	80%
1	Yes	5	28%	1	20%
	QIIIG8. Turning Surfaces				
G8a	None - Skin for all turning surfaces are intact	9	90%	2	100%
G8b	Right Hip	—	—	—	—
G8c	Left Hip	—	—	—	—
G8b, G8c	Right Hip AND Left Hip	—	—	—	—
G8d	Back/Buttocks	1	10%	—	—
G8b, G8d	Right Hip AND Back/Buttocks	—	—	—	—
G8c, G8d	Left Hip AND Back/Buttocks	—	—	—	—
G8b, G8c, G8d	Right Hip AND Left Hip AND Back/Buttocks	—	—	—	—
	IV. Cognitive Status				
	QIVA1. Patient Comatose				
0	No	24	96%	9	100%
1	Yes	1	4%	—	—
	QIVB1. BIMS Attempted				
0	No	2	8%	2	22%
1	Yes	24	92%	7	78%
	QIVB1A. Reason for no BiMS				
1	unresponsive	—	—	—	—
2	communication disorder	—	—	—	—
3	no interpreter available	—	—	—	—
4	other	1	100%	2	100%
	QIVB2. Repetition of Three Words				
—	None	1	4%	—	—
—	One	—	—	—	—
—	Two	—	—	—	—
—	Three	24	96%	7	100%
—	***out of range***	—	—	—	—
	QIVB3A. Current Year?				
—	Missed by more than 5 years or no answer	1	4%	—	—
—	Missed by 2 to 5 years	—	—	—	—
—	Missed by 1 year	1	4%	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
—	Correct	22	92%	6	100%
—	***out of range***	—	—	—	—
	QIVB3B. Current Month				
—	Missed by more than 1 month	1	4%	—	—
—	Missed by 6 days to 1 month	1	4%	—	—
—	Accurate within 5 days	22	92%	6	100%
—	—	—	—	—	—
—	—	—	—	—	—
	QIVB4. Recalls Sock				
—	No, could not recall	—	—	—	—
—	Yes, after cueing ("something to wear")	2	8%	—	—
—	Yes, no cue required	22	92%	7	100%
—	—	—	—	—	—
	QIVB5. Recalls Blue				
—	No, could not recall	—	—	—	—
—	Yes, after cueing ("a color")	2	8%	—	—
—	Yes, no cue required	22	92%	7	100%
—	—	—	—	—	—
	QIVB6. Recalls Bed				
—	No, could not recall	2	9%	—	—
—	Yes, after cueing ("a piece of furniture")	2	9%	1	14%
—	Yes, no cue required	19	83%	6	86%
—	—	—	—	—	—
	QIVC1. Short Term Memory				
—	Memory OK	18	86%	8	100%
—	Memory problem	3	14%	—	—
—	Unable to assess	—	—	—	—
	QIVC2. Long Term Memory				
—	Memory OK	18	86%	8	100%
—	Memory problem	3	14%	—	—
—	Unable to assess	—	—	—	—
	QIVC3. Memory Recall Ability				
C3a	Current season	4	19%	—	—
C3b	Location of own room	—	—	—	—
C3a, C3b	Current season AND Location of own room	3	14%	1	17%
C3c	Staff names and faces	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
C3a, C3c	Current season AND Staff names and faces	—	—	—	—
C3a, C3b, C3c	Current season AND Location of own room AND Staff names and faces	1	5%	1	17%
C3d	That he or she is in a hospital (or nursing home or home)	—	—	—	—
C3a, C3d	Current season AND That he or she is in a hospital (or nursing home or home)	—	—	—	—
C3a, C3b, C3d	Current season AND Location of own room AND That he or she is in a hospital (or nursing home or home)	1	5%	—	—
C3c, C3d	Staff names and faces AND That he or she is in a hospital (or nursing home or home)	—	—	—	—
C3a, C3c, C3d	Current season AND Staff names and faces AND That he or she is in a hospital (or nursing home or home)	—	—	1	17%
C3b, C3c, C3d	Location of own room AND Staff names and faces AND That he or she is in a hospital (or nursing home or homes)	—	—	—	—
C3a, C3b, C3c, C3d	Current season AND Location of own room AND Staff names and faces AND That he or she is in a hospital (or nursing home or home)	10	48%	3	50%
C3e	None of the above are recalled or unable to assess	—	—	—	—
C3a, C3b, C3e	Current season AND Location of own room AND None of the above are recalled or unable to assess	1	5%	—	—
C3a, C3b, C3c, C3d, C3e	Current season AND Location of own room AND Staff names and faces AND That he or she is in a hospital (or nursing home or home) AND None of the above are recalled or unable to assess	1	5%	—	—
	QIVC4. Daily Decisionmaking				
0	Independent: decisions consistently reasonable	14	82%	5	100%

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
1	Impaired: some difficulty or decisions poor; supervision required	3	18%	—	—
9	Unable to assess	—	—	—	—
—	***out of range***	—	—	—	—
	QIVD1. Inattention				
0	Behavior is not present	18	82%	8	100%
1	Behavior continuously present, does not fluctuate.	1	5%	—	—
2	Behavior present, fluctuates (comes and goes, changes in severity)	3	14%	—	—
—	***out of range***	—	—	—	—
	QIVD2. Disorganized Thinking				
0	Behavior is not present	22	96%	8	100%
1	Behavior continuously present, does not fluctuate.	—	—	—	—
2	Behavior present, fluctuates (comes and goes, changes in severity)	1	4%	—	—
—	***out of range***	—	—	—	—
	QIVD3. Level of Alertness				
0	Behavior is not present	20	91%	8	100%
1	Behavior continuously present, does not fluctuate.	—	—	—	—
2	Behavior present, fluctuates (comes and goes, changes in severity)	2	9%	—	—
—	***out of range***	—	—	—	—
	QIVD4. Psychomotor Retardation				
0	Behavior is not present	17	74%	8	100%
1	Behavior continuously present, does not fluctuate.	1	4%	—	—
2	Behavior present, fluctuates (comes and goes, changes in severity)	5	22%	—	—
—	—	—	—	—	—
	QIVE1. Aggressive to Others				
0	No	25	100%	8	100%
1	Yes	—	—	—	—
—	***out of range***	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QIVE2. Verbally Abusive to Others				
0	No	25	96%	8	100%
1	Yes	1	4%	—	—
—	***out of range***	—	—	—	—
	QIVE3. Disruptive Behavior				
0	No	26	100%	8	100%
1	Yes	—	—	—	—
—	***out of range***	—	—	—	—
	QIVF1. Mood Interview Attempted				
0	No	1	4%	1	13%
1	Yes	25	96%	7	88%
—	***out of range***	—	—	—	—
	QIVF2A. No Pleasure				
0	No	15	58%	8	100%
1	Yes	11	42%	—	—
9	Unable to respond	—	—	—	—
	QIVF2B. Days no interest				
0	not at all (0 to 1 days)	5	31%	—	—
1	several days (2 to 6 days)	5	31%	—	—
2	more than half of the days (7 to 11 days)	2	13%	—	—
3	nearly every day (12 to 14 days)	4	25%	—	—
—	***out of range***	—	—	—	—
	QIVF2C. Hopelessness				
0	No	17	65%	7	100%
1	Yes	9	35%	—	—
9	Unable to respond	—	—	—	—
	QIVF2D. Days Hopeless				
0	not at all (0 to 1 days)	4	31%	1	100%
1	several days (2 to 6 days)	4	31%	—	—
2	more than half of the days (7 to 11 days)	3	23%	—	—
3	nearly every day (12 to 14 days)	2	15%	—	—
—	***out of range***	—	—	—	—
	QIVF3. Feeling Sad				
0	Never	8	31%	5	71%
1	Rarely	7	27%	2	29%
2	Sometimes	7	27%	—	—
3	Often	3	12%	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
4	Always	1	4%	—	—
9	Unable to respond	—	—	—	—
	QIVG1. Fatigue Interview Attempted				
0	No	6	23%	—	—
1	Yes	20	77%	7	100%
—	***out of range***	—	—	—	—
	QIVG2. Fatigue				
0	Never	2	10%	5	71%
1	Rarely	3	14%	1	14%
2	Sometimes	7	33%	1	14%
3	Often	7	33%	—	—
4	Always	2	10%	—	—
9	Unable to respond	—	—	—	—
	QIVH1. Pain Interview Attempted				
0	No	4	15%	2	22%
1	Yes	22	85%	7	78%
—	***out of range***	—	—	—	—
	QIVH2. Pain Presence				
0	No	7	30%	4	57%
1	Yes	16	70%	3	43%
9	Unable to respond	—	—	—	—
	QIVH3. Pain Severity VAS				
—	No pain	1	6%	1	25%
1	1	—	—	—	—
—	2	—	—	—	—
—	3	1	6%	—	—
—	4	2	12%	2	50%
—	5	3	18%	—	—
—	6	2	12%	1	25%
—	7	—	—	—	—
—	8	5	29%	—	—
—	9	2	12%	—	—
—	Worst pain you can imagine	—	—	—	—
—	***out of range***	—	—	—	—
—	patient does not answer or is unable to respond	1	6%	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QIVH4. Pain Severity Likert				
1	Mild	5	29%	1	33%
2	Moderate	5	29%	1	33%
3	Severe	5	29%	—	—
4	Very severe, horrible	2	12%	1	33%
9	Unable to answer or no response	—	—	—	—
	QIVH5A. Pain Hard to Sleep				
0	No	13	76%	3	100%
1	Yes	4	24%	—	—
9	Unable to answer or no response	—	—	—	—
	QIVH5B. Pain Limits Activity				
0	No	8	47%	1	33%
1	Yes	9	53%	2	67%
9	Unable to answer or no response	—	—	—	—
	QIVH6. Pain Observational Assessment				
G6a	Non-verbal sounds	—	—	—	—
G6b	Vocal complaints of pain	—	—	—	—
G6c	Facial Expressions	—	—	1	50%
G6a, G6c	Non-verbal sounds AND Facial Expressions	—	—	—	—
G6b, G6c	Vocal complaints of pain AND Facial Expressions	1	33%	—	—
G6a, G6b, G6c	Non-verbal sounds AND Vocal complaints of pain AND Facial expressions	—	—	—	—
G6d	Protective body movements or postures	—	—	—	—
G6a, G6d	Non-verbal sounds AND Protective body movements or postures	—	—	—	—
G6a, G6b, G6d	Non-verbal sounds AND Vocal complaints of pain AND Protective body movements or postures	—	—	—	—
G6d, G6c	Protective body movements or postures AND Facial expressions	—	—	—	—
G6a, G6c, G6d	Non-verbal sounds AND Facial Expressions AND Protective body movements or postures	—	—	—	—
G6b, G6c, G6d	Vocal complaints of pain AND Facial Expressions AND Protective body movements or postures	1	33%	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
G6a, G6b, G6c, G6d, G6e	Non-verbal sounds AND Vocal complaints of pain AND Facial Expressions AND Protective body movements or postures AND None	—	—	—	—
G6e	None	1	33%	1	50%
	V. Impairments				
	QVA1A. Bladder Incontinence				
0	No	23	92%	9	100%
1	Yes	2	8%	—	—
	QVA1B. Bowel Incontinence				
0	No	26	100%	9	100%
1	Yes	—	—	—	—
	QVA2A. Bladder Incontinence Frequency				
0	Continent	16	67%	7	88%
1	Incontinent less than daily	4	17%	1	13%
2	Incontinent daily	1	4%	—	—
3	Always incontinent	3	13%	—	—
4	No urine/bowel output during the last 2 days	—	—	—	—
	QVA2B. Bowel Incontinence Frequency				
0	Continent	23	88%	7	88%
1	Incontinent less than daily	2	8%	1	13%
2	Incontinent daily	—	—	—	—
3	Always incontinent	1	4%	—	—
4	No urine/bowel output during the last 2 days	—	—	—	—
	QVA3A. Bladder				
0	No	21	88%	6	86%
1	Yes	3	13%	1	14%
	QVA3B. Bowel				
0	No	22	88%	6	86%
1	Yes	3	12%	1	14%
	QVB1. Swallowing Disorder Signs				
B1a	No sign or symptom of a possible swallowing disorder	25	96%	8	100%
B1b	Complaints of difficulty or pain with swallowing	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
B1c	Coughing or choking during meals or when swallowing medications	1	4%	—	—
—	—	—	—	—	—
B1d	Holding food in mouth/cheeks or residual food in mouth after meals	—	—	—	—
B1e	Loss of liquids/solids from mouth when eating or drinking	—	—	—	—
B1f	***out of range***	—	—	—	—
	QVB2. Usual ability to swallow				
1	Tube/parenteral feedings	—	—	—	—
2	Modified food consistency/supervision	—	—	—	—
3	Regular food	26	100%	7	100%
	QVC1. Comprehension				
1	Rarely/never understands	—	—	1	11%
2	Usually/sometimes understands	4	17%	1	11%
3	Understands	20	83%	7	78%
9	Unable to assess	—	—	—	—
	QVC2. Expression				
1	Rarely/Never expresses self or speech is very difficult to understand	—	—	—	—
2	Exhibits difficulty with expressing needs and ideas or speech is not clear	2	8%	—	—
3	Expresses complex messages without difficulty and with speech that is clear and easy to understand	22	92%	9	100%
9	Unable to assess	—	—	—	—
	QVC3. Vision				
1	Severely Impaired	—	—	—	—
2	Mildly to Moderately Impaired	6	24%	1	11%
3	Adequate	19	76%	8	89%
9	Unable to assess	—	—	—	—
	QVC4. Hearing				
1	Severely Impaired	2	8%	—	—
2	Mildly to Moderately Impaired	5	20%	1	11%
3	Adequate	18	72%	8	89%
9	Unable to assess	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QVD1A. L Shoulder ROM				
0	Limited Range of Motion	6	23%	—	—
1	Within Normal Limits	20	77%	9	100%
	QVD1B. L Elbow ROM				
0	Limited Range of Motion	3	12%	—	—
1	Within Normal Limits	23	88%	8	100%
	QVD1C. R Shoulder ROM				
0	Limited Range of Motion	8	31%	—	—
1	Within Normal Limits	18	69%	9	100%
	QVD1D. R Elbow ROM				
0	Limited Range of Motion	5	19%	—	—
1	Within Normal Limits	21	81%	9	100%
	QVE1A. L UE Weightbearing				
0	Not fully weight-bearing	25	100%	9	100%
1	Fully weight-bearing:	—	—	—	—
	QVE1B. R UE Weightbearing				
0	Not fully weight-bearing	25	100%	9	100%
1	Fully weight-bearing:	—	—	—	—
	QVE1C. L LE Weightbearing				
0	Not fully weight-bearing	25	100%	8	100%
1	Fully weight-bearing:	—	—	—	—
	QVE1D. R LE Weightbearing				
0	Not fully weight-bearing	22	88%	7	78%
1	Fully weight-bearing:	3	12%	2	22%
	QVE1E. Buttocks				
0	Not fully weight-bearing	21	95%	9	100%
1	Fully weight-bearing:	1	5%	—	—
	QVF1. Shortness of Breath				
0	Never, patient was not short of breath	6	23%	7	78%
1	When climbing stairs	6	23%	2	22%
2	With moderate exertion	10	38%	—	—
3	With minimal exertion	3	12%	—	—
4	At rest	1	4%	—	—
9	Not assessed	—	—	—	—
	QVG1. Stop to rest when walking				
0	No	10	38%	6	67%
1	Yes	11	42%	1	11%
9	Not assessed	5	19%	2	22%

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	VI. Functional Status				
	QVIA1. Toilet Hygiene				
0	Not attempted, not finished, or not applicable	—	—	—	—
1	Dependent	1	4%	—	—
2	Substantial/Maximal Assistance	—	—	1	11%
3	Partial/Moderate Assistance	1	4%	—	—
4	Supervision or Touching Assistance	1	4%	—	—
5	Setup or Clean-up Assistance	5	20%	—	—
6	Independent	17	68%	8	89%
	QVIA2. Oral Hygiene				
0	Not attempted, not finished, or not applicable	—	—	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	1	4%	—	—
4	Supervision or Touching Assistance	1	4%	—	—
5	Setup or Clean-up Assistance	3	12%	1	11%
6	Independent	20	80%	8	89%
	QVIA3. Eating				
0	Not attempted, not finished, or not applicable	—	—	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	1	4%	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	4	16%	—	—
6	Independent	20	80%	9	100%
	QVIA4. Tube Feeding				
0	Not attempted, not finished, or not applicable	9	90%	3	75%
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	1	10%	—	—
5	Setup or Clean-up Assistance	—	—	—	—
6	Independent	—	—	1	25%

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QVIB1. Walk 50 ft				
0	Not attempted, not finished, or not applicable	3	16%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	1	5%	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	2	11%	1	11%
6	Independent	13	68%	8	89%
	QVIB2. Walk in Room Once Standing				
0	Not attempted, not finished, or not applicable	1	5%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	2	10%	1	11%
6	Independent	18	86%	8	89%
	QVIB3. Toilet Transfer				
0	Not attempted, not finished, or not applicable	—	—	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	1	4%	—	—
3	Partial/Moderate Assistance	—	—	1	11%
4	Supervision or Touching Assistance	1	4%	—	—
5	Setup or Clean-up Assistance	2	9%	—	—
6	Independent	19	83%	8	89%
	QVIB4. Chair/Bed-to-Chair Transfer				
0	Not attempted, not finished, or not applicable	—	—	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	1	4%	—	—
3	Partial/Moderate Assistance	—	—	1	13%
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	3	13%	—	—
6	Independent	19	83%	7	88%

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QVIB5. Sit to Stand				
0	Not attempted, not finished, or not applicable	—	—	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	1	4%	—	—
3	Partial/Moderate Assistance	1	4%	1	11%
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	2	9%	—	—
6	Independent	19	83%	8	89%
	QVIB6. Lying to Sitting on Side of Bed				
0	Not attempted, not finished, or not applicable	1	4%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	1	4%	1	11%
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	3	13%	—	—
6	Independent	18	78%	8	89%
	QVIB7. Use Wheelchair?				
0	No	20	91%	9	100%
1	Yes	2	9%	—	—
	QVIB8. Wheel 50 ft - Interior				
0	Not attempted, please specify below	—	—	—	—
1	Dependent	1	33%	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	1	33%	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	—	—	—	—
6	Independent	1	33%	—	—
	QVIB9. Wheel in Room Once Seated				
0	Not attempted, please specify below	—	—	—	—
1	Dependent	1	33%	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	—	—	—	—
6	Independent	2	67%	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QVIC1. Sponge Bath				
0	Not attempted, please specify below	4	50%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	—	—	1	33%
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	2	25%	—	—
6	Independent	2	25%	2	67%
	QVIC2. Sit to Lying				
0	Not attempted, please specify below	5	63%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	—	—	—	—
6	Independent	3	38%	3	100%
	QVIC3. Roll left or right				
0	Not attempted, please specify below	5	63%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	—	—	—	—
6	Independent	3	38%	3	100%
—	***out of range***	—	—	—	—
	QVID1. Upper Body Dressing				
0	Not attempted, please specify below	2	18%	—	—
1	Dependent	1	9%	—	—
2	Substantial/Maximal Assistance	1	9%	—	—
3	Partial/Moderate Assistance	—	—	1	25%
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	1	9%	—	—
6	Independent	6	55%	3	75%
	QVID2. Shower/Bathe Self				
0	Not attempted, please specify below	3	30%	—	—
1	Dependent	2	20%	—	—
2	Substantial/Maximal Assistance	—	—	1	25%
3	Partial/Moderate Assistance	—	—	1	25%

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	2	20%	—	—
6	Independent	3	30%	2	50%
	QVID3. Picking up				
0	Not attempted, please specify below	3	27%	—	—
1	Dependent	3	27%	2	50%
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	1	9%	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	—	—	—	—
6	Independent	4	36%	2	50%
	QVID4. I step (curb)				
0	Not attempted, please specify below	3	27%	—	—
1	Dependent	1	9%	1	25%
2	Substantial/Maximal Assistance	1	9%	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	1	9%	1	25%
5	Setup or Clean-up Assistance	1	9%	—	—
6	Independent	4	36%	2	50%
	QVID5. Short ramp				
0	Not attempted, please specify below	1	33%	—	—
1	Dependent	1	33%	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	—	—	—	—
6	Independent	1	33%	1	100%
	QVIE1. Lower Body dressing				
0	Not attempted, please specify below	1	8%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	2	17%	—	—
4	Supervision or Touching Assistance	2	17%	—	—
5	Setup or Clean-up Assistance	2	17%	—	—
6	Independent	5	42%	7	100%
	QVIE2. 12 steps-interior				
0	Not attempted, please specify below	3	27%	—	—
1	Dependent	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	1	9%	—	—
4	Supervision or Touching Assistance	1	9%	—	—
5	Setup or Clean-up Assistance	3	27%	3	43%
6	Independent	3	27%	4	57%
	QVIE3. 4 steps-exterior				
0	Not attempted, please specify below	3	27%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	1	9%	—	—
4	Supervision or Touching Assistance	1	9%	—	—
5	Setup or Clean-up Assistance	1	9%	2	33%
6	Independent	5	45%	4	67%
	QVIE4. Walk longer distances-interior				
0	Not attempted, please specify below	4	36%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	1	9%	—	—
4	Supervision or Touching Assistance	1	9%	—	—
5	Setup or Clean-up Assistance	2	18%	1	14%
6	Independent	3	27%	6	86%
	QVIE5. Wheel longer distances-interior				
0	Not attempted, please specify below	1	100%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	—	—	—	—
6	Independent	—	—	—	—
	QVIE6. Long ramp-exterior				
0	Not attempted, please specify below	1	100%	—	—
1	Dependent	—	—	—	—
2	Substantial/Maximal Assistance	—	—	—	—
3	Partial/Moderate Assistance	—	—	—	—
4	Supervision or Touching Assistance	—	—	—	—
5	Setup or Clean-up Assistance	—	—	—	—
6	Independent	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QVIF1. Laundry				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	4	25%	1	14%
2	Maximum Assistance	7	44%	1	14%
3	Minimal Assistance	3	19%	1	14%
4	Independent	2	13%	4	57%
	QVIF2. Make light meal				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	2	13%	—	—
2	Maximum Assistance	2	13%	—	—
3	Minimal Assistance	6	38%	1	14%
4	Independent	6	38%	6	86%
	QVIF3. Dishwashing-By Hand				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	2	13%	—	—
2	Maximum Assistance	3	19%	—	—
3	Minimal Assistance	6	38%	1	20%
4	Independent	1	6%	4	80%
—	***out of range***	4	25%	—	—
	QVIF4. Dishwashing-Machine				
0	Not attempted, please specify below	1	7%	1	17%
1	Dependent (Total Assistance)	1	7%	—	—
2	Maximum Assistance	5	36%	—	—
3	Minimal Assistance	2	14%	2	33%
4	Independent	5	36%	3	50%
	QVIF5. Wipe down surface				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	1	6%	—	—
2	Maximum Assistance	1	6%	—	—
3	Minimal Assistance	3	19%	1	14%
4	Independent	11	69%	6	86%
	QVIF6. Telephone-Answering				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—
2	Maximum Assistance	—	—	—	—
3	Minimal Assistance	1	6%	—	—
4	Independent	11	69%	7	100%
—	***out of range***	4	25%	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QVIF7. Telephone-Placing Call				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—
2	Maximum Assistance	1	6%	—	—
3	Minimal Assistance	1	6%	—	—
4	Independent	14	88%	7	100%
	QVIF8. Medication Management - Oral Medications				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	1	6%	—	—
2	Maximum Assistance	1	6%	—	—
3	Minimal Assistance	3	19%	—	—
4	Independent	11	69%	6	100%
—	***out of range***	—	—	—	—
	QVIF9. Medication Management-Inhalation/Mist Medications				
0	Not attempted, please specify below	6	50%	—	—
1	Dependent (Total Assistance)	—	—	—	—
2	Maximum Assistance	—	—	—	—
3	Minimal Assistance	2	17%	—	—
4	Independent	4	33%	5	100%
—	***outside correct range***	—	—	—	—
	QVIF10. Medication Management-Injectable Medications				
0	Not attempted, please specify below	7	78%	2	50%
1	Dependent (Total Assistance)	2	22%	—	—
2	Maximum Assistance	—	—	—	—
3	Minimal Assistance	—	—	—	—
4	Independent	—	—	2	50%
	QVIG1. Get in/out of car				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—
2	Maximum Assistance	—	—	1	14%
3	Minimal Assistance	—	—	—	—
4	Independent	—	—	6	86%
	QVIG2. Light shopping				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	—	—	1	14%

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
2	Maximum Assistance	—	—	—	—
3	Minimal Assistance	—	—	2	29%
4	Independent	—	—	4	57%
	QVIG3. Walk a block				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—
2	Maximum Assistance	—	—	—	—
3	Minimal Assistance	—	—	2	29%
4	Independent	—	—	5	71%
—	outside correct range	—	—	—	—
	QVIG4. Use Public Transportation				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—
2	Maximum Assistance	—	—	—	—
3	Minimal Assistance	—	—	2	29%
4	Independent	—	—	5	71%
	QVIG5. Drive a car				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	—	—	2	40%
2	Maximum Assistance	—	—	—	—
3	Minimal Assistance	—	—	—	—
4	Independent	—	—	3	60%
	QVIG6. Wheel a block				
0	Not attempted, please specify below	—	—	—	—
1	Dependent (Total Assistance)	—	—	—	—
2	Maximum Assistance	—	—	—	—
3	Minimal Assistance	—	—	—	—
4	Independent	—	—	—	—
	QVIH1. Surprised at patient readmittance to hospital in next 3-6 months?				
0	No	13	57%	1	13%
1	Yes	10	43%	7	88%
9	Not assessed/don't know	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QVIH2. Surprised if patient dies in next 6-12 months?				
0	No	8	32%	1	13%
1	Yes	16	64%	7	88%
9	Not assessed/don't know	1	4%	—	—
	VII. Discharge Status				
	QVIIB1. Discharge location				
1	Private residence	—	—	8	89%
2	Other community-based residence setting	—	—	—	—
3	Long-term care facility/nursing home	—	—	—	—
4	Skilled nursing facility	—	—	—	—
5	Inpatient rehabilitation hospital or unit	—	—	1	11%
6	Long-term care hospital	—	—	—	—
7	Short-stay acute hospital	—	—	—	—
8	Hospice care	—	—	—	—
9	Psychiatric Hospital or unit	—	—	—	—
10	Other	—	—	—	—
11	Discharged against medical advice	—	—	—	—
12	Expired	—	—	—	—
	QVIIB2. Structural Barrier				
B2a	Structural barriers are not an issue.	—	—	6	75%
B2b	Stairs inside the living setting that must be used by patient (e.g., to get to toileting, sleeping, eating areas).	—	—	1	13%
B2c	Stairs leading from inside to outside of living setting.	—	—	1	13%
B2b, B2c	Stairs inside the living setting that must be used by patient (e.g., to get to toileting, sleeping, eating areas) AND Stairs leading from inside to outside of living setting.	—	—	—	—
B2d	Narrow or obstructed doorways	—	—	—	—
B2c, B2d	Stairs leading from inside to outside of living setting AND Narrow or obstructed doorways for patients using wheelchairs or walkers.	—	—	—	—
B2e	Insufficient space to accommodate extra equipment (e.g. hospital bed, vent equipment)	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
B2b, B2c, B2d, B2e	Stairs inside the living setting that must be used by patient AND Stairs leading from inside to outside AND Narrow or obstructed doorways AND Insufficient space to accommodate extra equipment (e.g. hospital bed, vent equipment)	—	—	—	—
	QVIIC1. Live With on Discharge				
C1a	Will live Alone	—	—	3	33%
C1b	Spouse or Significant other.	—	—	4	44%
C1c	Adult child (> 18 years).	—	—	1	11%
C1b, C1c	Spouse or Significant other AND Adult child (> 18 years).	—	—	1	11%
C1d	Other unpaid family member or friend.	—	—	—	—
C1a, C1d	Will live Alone AND Other unpaid family member or friend.	—	—	—	—
C1b, C1d	Spouse or Significant other AND Other unpaid family member or friend.	—	—	—	—
C1c, C1d	Adult child (>18 years) AND Other unpaid family member or friend.	—	—	—	—
C1e	Paid help, other than home care agency.	—	—	—	—
C1a, C1e	Will live Alone AND Paid help other than home care agency	—	—	—	—
C1b, C1e	Spouse or Significant other AND Paid help, other than home care agency	—	—	—	—
C1d, C1e	Other unpaid family member or friend AND Paid help other than home care agency	—	—	—	—
	QVIIC2. Frequency of Assistance				
1	Does not require assistance	—	—	4	50%
2	Weekly or less	—	—	2	25%
3	Less than daily but more often than weekly	—	—	—	—
4	Intermittently during the day or night	—	—	1	13%
5	All night but not during the day	—	—	—	—
6	All day but not at night	—	—	1	13%
7	24 hours per day	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	QVIIC3. Caregiver Availability				
0	No	—	—	—	—
1	Yes	—	—	6	100%
	QVIIC4. Type of Caregiver				
C4a	Spouse or Significant other.	—	—	2	33%
C4b	Adult child (> 18 years).	—	—	4	67%
C4a, C4b	Spouse or Significant other AND Adult child (>18 years)	—	—	—	—
C4c	Other unpaid family member or friend.	—	—	—	—
C4a, C4c	Spouse or Significant other AND Other unpaid family member or friend.	—	—	—	—
C4b, C4c	Adult child (> 18 years) AND Other unpaid family member or friend	—	—	—	—
C4d	Paid help, other than home care agency.	—	—	—	—
C4a, C4d	Spouse or Significant other AND Paid help, other than home care agency	—	—	—	—
C4c, C4d	Other unpaid family member or friend AND Paid help, other than home care agency	—	—	—	—
	QVIIC5A. Able to pay for meds				
0	Unable to assess	—	—	—	—
1	No	—	—	—	—
2	Yes	—	—	6	86%
3	Unknown	—	—	1	14%
	QVIIC5B. Transport to clinic				
0	Unable to assess	—	—	—	—
1	No follow up physician appointments and/or outpatient therapies or treatments planned	—	—	—	—
2	Can drive self	—	—	2	29%
3	Family member or friend will drive patient	—	—	5	71%
4	Public transportation	—	—	—	—
5	Other	—	—	—	—
	QVIID1. HHA PAC				
1	Deemed Appropriate by the Provider.	—	—	1	100%
2	Bed Available.	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—

(continued)

Table E-1c (continued)
Frequency distribution of responses to multiple choice and select all that apply questions for those answering the question
HHA

Code	Value Choices	HHA Admission Respondents to Question	HHA Admission % Distribution	HHA Discharge Respondents to Question	HHA Discharge % Distribution
	AVIID2. SNF PAC				
1	Deemed Appropriate by the Provider.	—	—	—	—
2	Bed Available.	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—
	QVIID3. IRF PAC				
1	Deemed Appropriate by the Provider.	—	—	1	100%
2	Bed Available.	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—
	QVIID4. LTCH PAC				
1	Deemed Appropriate by the Provider.	—	—	—	—
2	Bed Available.	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—
	QVIID5. PSYCH PAC				
1	Deemed Appropriate by the Provider.	—	—	—	—
2	Bed Available.	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—
	QVIID6. OTHER PAC				
1	Deemed Appropriate by the Provider.	—	—	1	100%
2	Bed Available.	—	—	—	—
4	Refused by Patient/Family.	—	—	—	—
	QVIID7B. Discharge Provider Type				
—	HHA	—	—	—	—
—	SNF	—	—	1	50%
—	IRF	—	—	—	—
—	LTCH	—	—	1	50%
	QVIIE1. Patient discharge delayed				
0	No	—	—	7	88%
1	Yes	—	—	1	13%
	QVIIE2. Reason for Discharge Delay				
1	No bed available	—	—	1	100%
2	Services, equipment or medications not available	—	—	—	—
3	Family/support	—	—	—	—
4	Medical	—	—	—	—
5	Other	—	—	—	—

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APPENDIX F:
CARE TOOL
PAC ADMISSION AND DISCHARGE ASSESSMENTS,
03/04/08

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CARE Tool
PAC Admission

This instrument uses the phrase "2-day assessment period" to refer to the day of the admission and the next calendar day (ending at 11:59 PM), or, if the patient is admitted after noon, add an additional calendar day.

Signatures of Persons 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)	III A2-6	(MM/DD/YYYY)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

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

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

C7. Patient's Facility/Agency Identification Number (for internal tracking)

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

C8a. Admission Date

_____/_____/_____
MM DD YYYY

C8b. Birth Date

_____/_____/_____
MM DD YYYY

C9. Social Security Number (Optional)

|___|___|___|-|___|___|-|___|___|___|___|

Enter Code

C10. Gender

1. Male
2. Female

Check all that apply.

C11. Race/Ethnicity

- a. American Indian or Alaska Native
- b. Asian
- c. Black or African American
- d. Hispanic or Latino
- e. Native Hawaiian or Pacific Islander
- f. White
- g. Unknown

Enter Code

C12. Is English the patient's primary language?

0. No
1. Yes *(If Yes, skip to C13.)*

C12a. If English is not the patient's primary language, what is the patient's primary language?

_____

Enter Code

C13. Does the patient want or need an interpreter (oral or sign language) to communicate with a doctor or health care staff?

0. No
1. Yes

I. Administrative Items (cont.)

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)* _____

II. Admission Information

A. Pre-admission Service Use

Enter Code ☐

A1. Admitted From. Immediately preceding this admission, where was the patient?

1. **Directly from community** (e.g., private home, assisted living, group home, adult foster care)
2. **Long-term nursing facility**
3. **Skilled nursing facility** (SNF/TCU)
4. **Hospital emergency department**
5. **Short-stay acute hospital** (IPPS)
6. **Long-term care hospital** (LTCH)
7. **Inpatient rehabilitation hospital or unit** (IRF)
8. **Psychiatric hospital or unit**
9. **Other** (specify)_____

Check all that apply.

A3. In the last 2 months, what other medical services besides those identified in A1. has the patient received?

- ☐ a. **Skilled nursing facility** (SNF/TCU)
- ☐ b. **Short-stay acute hospital** (IPPS)
- ☐ c. **Long-term care hospital** (LTCH)
- ☐ d. **Inpatient rehabilitation hospital or unit** (IRF)
- ☐ e. **Psychiatric hospital or unit**
- ☐ f. **Home health care** (HHA)
- ☐ g. **Hospice**
- ☐ h. **Outpatient services**
- ☐ i. **None**

A2. If admitted from a medical setting, what was the primary diagnosis being treated in the previous setting?

A2a. _____

B. Patient History Prior To This Current Illness, Exacerbation, or Injury

Enter Code ☐

B1. Prior to this recent illness, where did the patient live?

<u>In Community</u>

1. **Private residence**
2. **Community based residence** (e.g., assisted living residence, group home, adult foster care)

<u>Other</u>

3. **Permanently in a long-term care facility** (e.g., nursing home) (*skip to B5. Prior Functioning*)
4. **Other** (e.g., shelter, jail, no known address) (*skip to B5. Prior Functioning*)
9. **Unknown** (*skip to B5. Prior Functioning*)

B2. If the patient lived in the community prior to this illness, provide the patient's ZIP Code (if patient's residence was in U.S.).

|___|___|___|___|___|

☐ **Lives Outside U.S.** ☐ **Unknown**

Check all that apply.

B3. If the patient lived in the community prior to this illness, what help was used?

- ☐ a. **No help received or no help necessary**
- ☐ b. **Unpaid Assistance**
- ☐ c. **Paid Assistance**
- ☐ d. **Unknown**

B3a. If the patient lived in the community prior to this illness, who did the patient live with?

- ☐ a. **Lives alone**
- ☐ b. **Lives with paid helper**
- ☐ c. **Lives with other(s)**
- ☐ d. **Unknown**

II. Admission Information (cont.)

B4. If the patient lived in the community prior to this current illness, exacerbation, or injury, are there any structural barriers in the patient's **prior residence** that could interfere with the patient's discharge?

Check all that apply.

- ☐ **a.** Structural barriers are **not an issue**.
- ☐ **b.** **Stairs inside the living setting** that must be used by patient (e.g., to get to toileting, sleeping, eating areas).
- ☐ **c.** **Stairs leading from inside to outside** of living setting.
- ☐ **d.** **Narrow or obstructed doorways** for patients using wheelchairs or walkers.
- ☐ **e.** **Insufficient space** to accommodate **extra equipment** (e.g., hospital bed, vent equipment).
- ☐ **f.** **Other** (specify) _____.
- ☐ **g.** **Unknown**

B5. Prior Functioning. Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury.

3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.

2. Needed partial assistance – Patient needed partial assistance from another person to complete activities.

1. Dependent – A helper completed the activity for the patient.

8. Not Applicable

9. Unknown

Enter Code	
☐	**B5a. Self Care:** Did the patient need help bathing, dressing, using the toilet, or eating?
☐	**B5b. Mobility (Ambulation):** Did the patient need assistance with walking from room to room (with or without devices such as cane, crutch, or walker)?
☐	**B5c. Stairs (Ambulation):** Did the patient need assistance with stairs (with or without devices such as cane, crutch, or walker)?
☐	**B5d. Mobility (Wheelchair):** Did the patient need assistance with moving from room to room using a wheelchair, scooter, or other wheeled mobility device?
☐	**B5e. Functional Cognition:** Did the patient need help planning regular tasks, such as shopping or remembering to take medication?

B6. Mobility Devices and Aids Used Prior to Current Illness, Exacerbation, or Injury

Check all that apply.

- ☐ **a. Cane/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**
- ☐ **i. Unknown**

Enter Code ☐

B7. History of Falls. Has the patient had two or more falls in the past year or any fall with injury in the past year?

0. No
1. Yes
9. Unknown

*T.II How long did it take you to complete the **II. Admission Information** 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. For discharge only, these lists can be added to throughout the stay and will be specific to each setting.

A. Primary and Other Diagnoses, Comorbidities, and Complications (Optional on PAC Admission only.)

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 on PAC Admission only.)

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 on PAC Admission only.)

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 ("Admitted With:" refers to the 2-day admission assessment period.)

Which of the following treatments did the patient receive at the time of the assessment?

Check all that apply.

Admitted With:	
D1a. ☐	**D1. None**
D2a. ☐	**D2. Insulin Drip**
D3a. ☐	**D3. Total Parenteral Nutrition**
D4a. ☐	**D4. Central Line Management**
D5a. ☐	**D5. Blood Transfusion(s)**
D6a. ☐	**D6. Controlled Parenteral Analgesia – Peripheral**
D7a. ☐	**D7. Controlled Parenteral Analgesia – Epidural**
D8a. ☐	**D8. Left Ventricular Assistive Device** (LVAD)
D9a. ☐	**D9. Continuous Cardiac Monitoring** ***D9c.*** *Specify reason for continuous monitoring:* _____
D10a. ☐	**D10. Chest Tube(s)**
D11a. ☐	**D11. Trach Tube with Suctioning** ***D11c.*** *Specify most intensive frequency of suctioning during stay:* *Every_____ hours*
D12a. ☐	**D12. High O2 Concentration Delivery System with FiO2 > 40%**
D13a. ☐	**D13. Non-invasive ventilation**
D14a. ☐	**D14. Ventilator – Weaning**
D15a. ☐	**D15. Ventilator – Non-Weaning**
D16a. ☐	**D16. Hemodialysis**
D17a. ☐	**D17. Peritoneal Dialysis**
D18a. ☐	**D18. Fistula or Other Drain Management**
D19a. ☐	**D19. Negative Pressure Wound Therapy**
D20a. ☐	**D20. Complex Wound Management** with positioning and skin separation/traction that requires at least two persons
D21a. ☐	**D21. Halo**
D22a. ☐	**D22. Complex External Fixators** (e.g., Ilizarov)
D23a. ☐	**D23. One-on-One 24-Hour Supervision** ***D23c.*** *Specify reason for 24-hour supervision:* _____
D24a. ☐	**D24. Specialty Surface or Bed** (i.e., air fluidized, bariatric, low air loss, or rotation bed)
D25a. ☐	**D25. Multiple IV Antibiotic Administration**
D26a. ☐	**D26. IV Vaso-actors** (e.g., pressors, dilators, medication for pulmonary edema)
D27a. ☐	**D27. IV Anti-coagulants**
D28a. ☐	**D28. IV Chemotherapy**
D29a. ☐	**D29. Indwelling Bowel Catheter Management System**
D30a. ☐	**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

III. Current Medical Information (cont.)

F. Allergies & Adverse Drug Reactions (Optional for PAC Admission.)

Enter Code

F1. Does patient **have allergies or any known adverse drug reactions?**
0. None known *(If **None known**, skip to Section G. Skin Integrity.)*
1. Yes *(If **Yes**, list all allergies/causes of reaction [e.g., food, medications, other] and describe the adverse reactions.)*

Allergies/Causes of Reaction	Patient Reaction
F1a. _____	F1b. _____
F2a. _____	F2b. _____
F3a. _____	F3b. _____
F4a. _____	F4b _____
F5a. _____	F5b. _____
F6a. _____	F6b. _____
F7a. _____	F7b. _____
F8a. _____	F8b. _____

Enter Code

F9. Is the list complete?
0. No
1. Yes

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

G1-2. PRESENCE OF PRESSURE ULCERS

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.**

Enter Code

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:

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

Number present at assessment	Pressure ulcer at stage 2, stage 3, or stage 4 only:
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	**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	**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	**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."

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**

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

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

Date Measured ____/____/____ MM DD YYYY

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):

a. **Longest length in any direction**

b. **Width of SAME unhealed ulcer or eschar**

c. **Date of measurement**

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: _____

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**

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 (ºF) OR
H6a. / /	xx.x	H6b.	H6c. ☐	H6. Temperature (ºC)
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/mm³)
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

A. Comatose (Complete during the 2-day assessment period.)

Enter Code

A1. Persistent vegetative state/no discernible consciousness at time of admission

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

B. Temporal Orientation/Mental Status (Complete during the 2-day assessment period.)

B1. Interview Attempted

Enter Code

B1a. Interview Attempted?

0. **No**
1. **Yes** *(If* **Yes**, *skip to B3. BIMS.)*

Enter Code

B1b. Indicate reason that the interview was not attempted *and then skip to Section C. Observational Assessment of Cognitive Status.*

1. **Unresponsive or minimally conscious**
2. **Communication disorder**
3. **No interpreter available**

B3. Brief Interview for Mental Status (Complete only for PAC Admission.)

Enter Code

B3a. Repetition of Three Words

Ask patient: *"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."*

Number of words repeated by patient after first attempt:

3. **Three**
2. **Two**
1. **One**
0. **None**

After the patient's first attempt say: *"I will repeat each of the three words with a cue and ask you about them later: sock, something to wear; blue, a color; bed, a piece of furniture."* **You may repeat the words up to two more times.**

Enter Code

B3b. Year, Month, Day

B3b.1. Ask patient: *"Please tell me what year it is right now."*

Patient's answer is:

3. **Correct**
2. **Missed by 1 year**
1. **Missed by 2 to 5 years**
0. **Missed by more than 5 years or no answer**

Enter Code

B3b.2. Ask patient: *"What month are we in right now?"*

Patient's answer is:

2. **Accurate within 5 days**
1. **Missed by 6 days to 1 month**
0. **Missed by more than 1 month or no answer**

Enter Code

B3b.3. Ask patient: *"What day of the week is today?"*

Patient's answer is:

2. **Accurate**
1. **Incorrect or no answer**

IV. Cognitive Status, Mood & Pain (cont.)

B3. Brief Interview for Mental Status (Complete only for PAC admission.) (cont.)

Enter Code

B3c. Recall
Ask patient: *"Let's go back to the first question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (i.e., something to wear; a color; a piece of furniture) for that word.

B3c.1. Recalls "sock?"
2. **Yes**, no cue required
1. **Yes**, after cueing ("something to wear")
0. **No**, could not recall

Enter Code

B3c.2. Recalls "blue?"
2. **Yes**, no cue required
1. **Yes**, after cueing ("a color")
0. **No**, could not recall

Enter Code

B3c.3. Recalls "bed?"
2. **Yes**, no cue required
1. **Yes**, after cueing ("a piece of furniture")
0. **No**, could not recall

C. Observational Assessment of Cognitive Status: Complete this section only if patient could not be interviewed. **(Complete during the 2-day assessment period.)**

Check all that apply.

C1. Memory/recall ability

- ☐ **C1a. Current season**
- ☐ **C1b. Location of own room**
- ☐ **C1c. Staff names and faces**
- ☐ **C1d. That he or she is in a hospital, nursing home, or home**
- ☐ **C1e. None of the above are recalled**
- ☐ **C1f. Unable to assess** ***Specify reason*** _____

D. Confusion Assessment Method: Complete this section only if patient scored 0 or 1 on B3b.1., B3b.2., or B3b.3. **(Complete during the 2-day assessment period.)**

CODING:
0. Behavior **is not present.**
1. Behavior **continuously present** does not fluctuate.
2. Behavior **present, fluctuates** (e.g., comes and goes, changes in severity).

Enter Code in Boxes →

Enter Code

D1. Inattention: The patient has difficulty focusing attention (e.g., easily distracted, out of touch, or difficulty keeping track of what is said).

Enter Code

D2. Disorganized thinking: The patient's thinking is disorganized or incoherent (e.g., rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching of topics or ideas).

Enter Code

D3. Altered level of consciousness/alertness: The patient has an altered level of consciousness: vigilant (e.g., startles easily to any sound or touch), lethargic (e.g., repeatedly dozes off when asked questions, but responds to voice or touch), stuporous (e.g., very difficult to arouse and keep aroused for the interview), or comatose (e.g., cannot be aroused).

Enter Code

D4. Psychomotor retardation: Patient has an unusually decreased level of activity (e.g., sluggishness, staring into space, staying in one position, moving very slowly).

IV. Cognitive Status, Mood & Pain (cont.)

E. Behavioral Signs & Symptoms (Complete during the 2-day assessment period.)

Has the patient exhibited any of the following behaviors during the 2-day assessment period?

Enter Code

E1. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing).
- **0. No**
- **1. Yes**

Enter Code

E2. Verbal behavioral symptoms directed towards others (e.g., threatening, screaming at others).
- **0. No**
- **1. Yes**

Enter Code

E3. Other disruptive or dangerous behavioral symptoms not directed towards others, including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs, pacing).
- **0. No**
- **1. Yes**

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

Enter Code

F1. Mood Interview Attempted?
- **0. No** *(If **No**, skip to G1. Pain Interview.)*
- **1. Yes**

F2. Patient Health Questionnaire (PHQ-2©)

Ask patient: *"During the last 2 weeks, have you been bothered by any of the following problems?"*

Enter Code

F2a. Little interest or pleasure in doing things?
- **0. No** *(If **No**, skip to question F2c.)*
- **1. Yes**
- **8. Unable to respond** *(If **Unable**, skip to question F2c.)*

Enter Code

F2b. If ***Yes***, how many days in the last 2 weeks?
- **0. Not at all (0 to 1 days)**
- **1. Several days (2 to 6 days)**
- **2. More than half of the days (7 to 11 days)**
- **3. Nearly every day (12 to 14 days)**

Enter Code

F2c. Feeling down, depressed, or hopeless?
- **0. No** *(If **No**, skip to question F3.)*
- **1. Yes**
- **8. Unable to respond** *(If **Unable**, skip to question F3.)*

Enter Code

F2d. If ***Yes***, how many days in the last 2 weeks?
- **0. Not at all (0 to 1 days)**
- **1. Several days (2 to 6 days)**
- **2. More than half of the days (7 to 11 days)**
- **3. Nearly every day (12 to 14 days)**

F3. Feeling Sad

Enter Code

F3. Ask patient: *"During the past 2 weeks, how often would you say, 'I feel sad'?"*
- **0. Never**
- **1. Rarely**
- **2. Sometimes**
- **3. Often**
- **4. Always**
- **8. Unable to respond**

IV. Cognitive Status, Mood & Pain (cont.)

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
A3a. Enter Code	A3b. Enter Code
A4a. Enter Code	A4b. Enter Code
A5a. Enter Code	A5b. Enter Code

A2. Does this patient use an **external or indwelling device** or require intermittent catheterization?
0. No
1. Yes

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)

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

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	**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.
Enter Code	**A2. Tube feeding:** The ability to manage all equipment/supplies related to obtaining nutrition.
Enter Code	**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.
Enter Code	**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.
Enter Code	**A5. Upper body dressing:** The ability to put on and remove shirt or pajama top. Includes buttoning three buttons.
Enter Code	**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

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.

Enter Code

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.

Enter Code

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.

Enter Code

B4. Toilet Transfer: The ability to safely get on and off a toilet or commode.

MODE OF MOBILITY

Enter Code

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.)

Enter Code

1. Walk 150 ft (45 m): Once standing, can walk at least150 feet (45 meters) in corridor or similar space.

Enter Code

2. Walk 100 ft (30 m): Once standing, can walk at least 100 feet (30 meters) in corridor or similar space

Enter Code

3. Walk 50 ft (15 m): Once standing, can walk at least 50 feet (15 meters) in corridor or similar space

Enter Code

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.)

Enter Code

1. Wheel 150 ft (45 m): Once sitting, can wheel at least 150 feet (45 meters) in corridor or similar space.

Enter Code

2. Wheel 100 ft (30 m): Once sitting, can wheel at least 100 feet (30 meters) in corridor or similar space

Enter Code

3. Wheel 50 ft (15 m): Once sitting, can wheel at least 50 feet (15 meters) in corridor or similar space

Enter Code

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 [1] 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
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	**C1. Wash Upper Body:** The ability to wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed.
Enter Code	**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.
Enter Code	**C3. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
Enter Code	**C4. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
Enter Code	**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.
Enter Code	**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	
Enter Code	**C7.** Does this patient primarily use a wheelchair for mobility? **0. No** *(If **No**, code C7a–C7f.)* **1. Yes** *(If **Yes**, code C7f–C7h.)*
Enter Code	**C7a. 1 step (curb):** The ability to step over a curb or up and down one step.
Enter Code	**C7b. Walk 50 feet with two turns:** The ability to walk 50 feet and make two turns.
Enter Code	**C7c. 12 steps-interior:** The ability to go up and down 12 interior steps with a rail.
Enter Code	**C7d. Four steps-exterior:** The ability to go up and down 4 exterior steps with a rail.
Enter Code	**C7e. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces, such as grass or gravel.
Enter Code	**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.
Enter Code	**C7g. Wheel short ramp:** Once seated in wheelchair, goes up and down a ramp of less than 12 feet (4 meters).
Enter Code	**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	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**C15. Light shopping:** Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.
Enter Code	**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.
Enter Code	**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 admission or at the time of a significant change in the patient's status affecting Medicare payment.

A. Principal Diagnosis (Optional on PAC Admission only.)

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 on PAC Admission only.)

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 on PAC Admission only.)

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.

CARE Tool
PAC Discharge

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

1) **The day of discharge and the calendar day before the day of discharge (beginning at 12:00 AM);**

or

2) **For Home Health, the day of the last visit or the day before the last visit.**

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.					

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

C9. Social Security Number (Optional)

|___|___|___|-|___|___|-|___|___|___|___|

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. For discharge only, these lists can be added to throughout the stay and will be specific to each setting.

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

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)

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 ("Discharged With:" refers to the 2-day discharge assessment period.)

Which of the following treatments did the patient receive at the time of the assessment?

Check all that apply.

Discharged With:	Used at Any Time During Stay:	
D1a. ☐	D1b. ☐	**D1. None**
D2a. ☐	D2b. ☐	**D2. Insulin Drip**
D3a. ☐	D3b. ☐	**D3. Total Parenteral Nutrition**
D4a. ☐	D4b. ☐	**D4. Central Line Management**
D5a. ☐	D5b. ☐	**D5. Blood Transfusion(s)**
D6a. ☐	D6b. ☐	**D6. Controlled Parenteral Analgesia – Peripheral**
D7a. ☐	D7b. ☐	**D7. Controlled Parenteral Analgesia – Epidural**
D8a. ☐	D8b. ☐	**D8. Left Ventricular Assistive Device** (LVAD)
D9a. ☐	D9b. ☐	**D9. Continuous Cardiac Monitoring** ***D9c.*** *Specify reason for continuous monitoring:* _____
D10a. ☐	D10b. ☐	**D10. Chest Tube(s)**
D11a. ☐	D11b. ☐	**D11. Trach Tube with Suctioning** ***D11c.*** *Specify most intensive frequency of suctioning during stay:* *Every_____ hours*
D12a. ☐	D12b. ☐	**D12. High O2 Concentration Delivery System with FiO2 > 40%**
D13a. ☐	D13b. ☐	**D13. Non-invasive ventilation**
D14a. ☐	D14b. ☐	**D14. Ventilator – Weaning**
D15a. ☐	D15b. ☐	**D15. Ventilator – Non-Weaning**
D16a. ☐	D16b. ☐	**D16. Hemodialysis**
D17a. ☐	D17b. ☐	**D17. Peritoneal Dialysis**
D18a. ☐	D18b. ☐	**D18. Fistula or Other Drain Management**
D19a. ☐	D19b. ☐	**D19. Negative Pressure Wound Therapy**
D20a. ☐	D20b. ☐	**D20. Complex Wound Management** with positioning and skin separation/ traction that requires at least two persons
D21a. ☐	D21b. ☐	**D21. Halo**
D22a. ☐	D22b. ☐	**D22. Complex External Fixators** (e.g., Ilizarov)
D23a. ☐	D23b. ☐	**D23. One-on-One 24-Hour Supervision** ***D23c.*** *Specify reason for 24-hour supervision:* _____
D24a. ☐	D24b. ☐	**D24. Specialty Surface or Bed** (i.e., air fluidized, bariatric, low air loss, or rotation bed)
D25a. ☐	D25b. ☐	**D25. Multiple IV Antibiotic Administration**
D26a. ☐	D26b. ☐	**D26. IV Vaso-actors** (e.g., pressors, dilators, medication for pulmonary edema)
D27a. ☐	D27b. ☐	**D27. IV Anti-coagulants**
D28a. ☐	D28b. ☐	**D28. IV Chemotherapy**
D29a. ☐	D29b. ☐	**D29. Indwelling Bowel Catheter Management System**
D30a. ☐	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

III. Current Medical Information (cont.)

F. Allergies & Adverse Drug Reactions

Enter Code

F1. Does patient **have allergies or any known adverse drug reactions?**
0. None known *(If **None known**, skip to Section G. Skin Integrity.)*
1. Yes *(If **Yes**, list all allergies/causes of reaction [e.g., food, medications, other] and describe the adverse reactions.)*

Allergies/Causes of Reaction	Patient Reaction
F1a. _____	**F1b.** _____
F2a. _____	**F2b.** _____
F3a. _____	**F3b.** _____
F4a. _____	**F4b** _____
F5a. _____	**F5b.** _____
F6a. _____	**F6b.** _____
F7a. _____	**F7b.** _____
F8a. _____	**F8b.** _____

Enter Code

F9. Is the list complete?
0. No
1. Yes

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

G1-2. PRESENCE OF PRESSURE ULCERS

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.**

Enter Code

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:

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

Number present at assessment	Number with onset during this service	Pressure ulcer at stage 2, stage 3, or stage 4 only:
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."

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**

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

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

Date Measured ____/____/____ MM DD YYYY

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):

a. **Longest length in any direction**

b. **Width of SAME unhealed ulcer or eschar**

c. **Date of measurement**

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: _____

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**

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/mm³)
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

E. Behavioral Signs & Symptoms (Complete during the 2-day assessment period.)

Has the patient exhibited any of the following behaviors during the 2-day assessment period?

Enter Code

E1. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing).
- **0. No**
- **1. Yes**

Enter Code

E2. Verbal behavioral symptoms directed towards others (e.g., threatening, screaming at others).
- **0. No**
- **1. Yes**

Enter Code

E3. Other disruptive or dangerous behavioral symptoms not directed towards others, including self-injurious behaviors (e.g., hitting or scratching self, attempts to pull out IVs, pacing).
- **0. No**
- **1. Yes**

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

Enter Code

F1. Mood Interview Attempted?
- **0. No** *(If **No**, skip to G1. Pain Interview.)*
- **1. Yes**

F2. Patient Health Questionnaire (PHQ-2©)

Ask patient: *"During the last 2 weeks, have you been bothered by any of the following problems?"*

Enter Code

F2a. Little interest or pleasure in doing things?
- **0. No** *(If **No**, skip to question F2c.)*
- **1. Yes**
- **8. Unable to respond** *(If **Unable**, skip to question F2c.)*

Enter Code

F2b. If ***Yes***, how many days in the last 2 weeks?
- **0. Not at all (0 to 1 days)**
- **1. Several days (2 to 6 days)**
- **2. More than half of the days (7 to 11 days)**
- **3. Nearly every day (12 to 14 days)**

Enter Code

F2c. Feeling down, depressed, or hopeless?
- **0. No** *(If **No**, skip to question F3.)*
- **1. Yes**
- **8. Unable to respond** *(If **Unable**, skip to question F3.)*

Enter Code

F2d. If ***Yes***, how many days in the last 2 weeks?
- **0. Not at all (0 to 1 days)**
- **1. Several days (2 to 6 days)**
- **2. More than half of the days (7 to 11 days)**
- **3. Nearly every day (12 to 14 days)**

F3. Feeling Sad

Enter Code

F3. Ask patient: *"During the past 2 weeks, how often would you say, 'I feel sad'?"*
- **0. Never**
- **1. Rarely**
- **2. Sometimes**
- **3. Often**
- **4. Always**
- **8. Unable to respond**

IV. Cognitive Status, Mood & Pain (cont.)

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 ☐
A3a. Enter Code ☐	A3b. Enter Code ☐
A4a. Enter Code ☐	A4b. Enter Code ☐
A5a. Enter Code ☐	A5b. Enter Code ☐

A2. Does this patient use an **external or indwelling device** or require intermittent catheterization?
0. No
1. Yes

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)

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

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	
Enter ☐ Code	**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.
Enter ☐ Code	**A2. Tube feeding:** The ability to manage all equipment/supplies related to obtaining nutrition.
Enter ☐ Code	**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.
Enter ☐ Code	**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.
Enter ☐ Code	**A5. Upper body dressing:** The ability to put on and remove shirt or pajama top. Includes buttoning three buttons.
Enter ☐ Code	**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

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.

Enter Code

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.

Enter Code

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.

Enter Code

B4. Toilet Transfer: The ability to safely get on and off a toilet or commode.

MODE OF MOBILITY

Enter Code

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.)

Enter Code
1. **Walk 150 ft (45 m):** Once standing, can walk at least150 feet (45 meters) in corridor or similar space.

Enter Code
2. **Walk 100 ft (30 m):** Once standing, can walk at least 100 feet (30 meters) in corridor or similar space

Enter Code
3. **Walk 50 ft (15 m):** Once standing, can walk at least 50 feet (15 meters) in corridor or similar space

Enter Code
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.)

Enter Code
1. **Wheel 150 ft (45 m):** Once sitting, can wheel at least 150 feet (45 meters) in corridor or similar space.

Enter Code
2. **Wheel 100 ft (30 m):** Once sitting, can wheel at least 100 feet (30 meters) in corridor or similar space

Enter Code
3. **Wheel 50 ft (15 m):** Once sitting, can wheel at least 50 feet (15 meters) in corridor or similar space

Enter Code
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	
	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	
Enter Code	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**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.
Enter Code	**C15. Light shopping:** Once at store, can locate and select up to five needed goods, take to check out, and complete purchasing transaction.
Enter Code	**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.
Enter Code	**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) _____

VIII. Discharge Status

A. Discharge Information

A1. Discharge Date

_____/_____/_____
MM DD YYYY

A2. Attending Physician (at this location)

A3. Discharge Location

Where will the patient be discharged to?

Enter Code

1. **Private residence**
2. **Other community-based residential setting** (e.g., assisted living residents, group home, adult foster care)
3. **Long-term nursing facility**
4. **Skilled nursing facility** (SNF/TCU)
5. **Short-stay acute hospital** (IPPS)
6. **Long-term care hospital** (LTCH)
7. **Inpatient rehabilitation hospital or unit** (IRF)
8. **Psychiatric hospital or unit**
9. **Facility-based hospice**
10. **Other** (e.g., shelter, jail, no known address)
11. **Discharged against medical advice**

A4. Frequency of Assistance at Discharge

How often will the patient require assistance (physical care or supervision) from a caregiver(s) or provider(s)?

Enter Code

1. Patient **does not require assistance** (*Skip to Section B. Residential Information.)*
2. **Weekly** or less (e.g., requires help with grocery shopping or errands, etc.)
3. **Less than daily** but more often than weekly
4. **Intermittently** and predictably during the day or night
5. **All night** but not during the day
6. **All day** but not at night
7. **24** hours per day, or standby services

A5. Caregiver(s) Availability

Enter Code

Was the discharge destination decision influenced by the availability of a family member or friend to provide assistance?

0. **No** *(If* **No,** *skip to Section B. Residential Information.)*
1. **Yes**

A6. Willing Caregiver(s)

Does the patient have one or more willing caregiver(s)?

Enter Code

0. **No** *(If* **No,** *skip to Section B. Residential Information.)*
1. **Yes, confirmed by caregiver**
2. **Yes, confirmed only by patient**
9. **Unclear from patient; no confirmation from caregiver**

A7. Types of Caregiver(s)

What is the relationship of the caregiver(s) to the patient?

Check all that apply.

- ☐ a. **Spouse or significant other**
- ☐ b. **Child**
- ☐ c. **Other unpaid family member or friend**
- ☐ d. **Paid help**

B. Residential Information: Complete only if patient is discharged to a private residence or other community-based setting.

B1. Patient Lives With at Discharge

Upon discharge (admission), who will the patient live with?

Check all that apply.

- ☐ a. **Lives alone**
- ☐ b. **Lives with paid helper**
- ☐ c. **Lives with other(s)**
- ☐ d. **Unknown**

VIII. Discharge Status (cont.)

C. Support Needs/Caregiver (CG) Assistance

Type of Assistance Needed Patient needs assistance with (check all that apply)		Support Needs/Caregiver Assistance (If patient needs assistance, check one on each row)			
		CG able	CG will need training and/or other supportive services	CG not likely to be able	CG ability unclear
☐ C1a	a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	☐ C2a	☐ C3a	☐ C4a	☐ C5a
☐ C1b	b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	☐ C2b	☐ C3b	☐ C4b	☐ C5b
☐ C1c	c. Medication administration (e.g., oral, inhaled, or injectable)	☐ C2c	☐ C3c	☐ C4c	☐ C5c
☐ C1d	d. Medical procedures/treatments (e.g., changing wound dressing)	☐ C2d	☐ C3d	☐ C4d	☐ C5d
☐ C1e	e. Management of equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment, or supplies)	☐ C2e	☐ C3e	☐ C4e	☐ C5e
☐ C1f	f. Supervision and safety	☐ C2f	☐ C3f	☐ C4f	☐ C5f
☐ C1g	g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	☐ C2g	☐ C3g	☐ C4g	☐ C5g
☐ C1h	h. None of the above				

VIII. Discharge Status (cont.)

D. Discharge Care Options

Please indicate whether the following services were considered appropriate for the patient at discharge; for those identified as potentially appropriate, were they: available, refused by family, or not covered by insurance. (Check all that apply.)

Type of Service	Considered Appropriate by the Provider	Bed/Services Available	Refused by Patient/Family	Not Covered by Insurance
a. Home Health Care (HHA)	☐ D1a	☐ D2a	☐ D3a	☐ D4a
b. Skilled Nursing Facility (SNF/TCU)	☐ D1b	☐ D2b	☐ D3b	☐ D4b
c. Inpatient Rehabilitation Hospital or Unit (IRF)	☐ D1c	☐ D2c	☐ D3c	☐ D4c
d. Long-Term Care Hospital (LTCH)	☐ D1d	☐ D2d	☐ D3d	☐ D4d
e. Psychiatric Hospital or Unit	☐ D1e	☐ D2e	☐ D3e	☐ D4e
f. Outpatient Services	☐ D1f	☐ D2f	☐ D3f	☐ D4f
g. Acute Hospital Admission	☐ D1g	☐ D2g	☐ D3g	☐ D4g
h. Hospice	☐ D1h	☐ D2h	☐ D3h	☐ D4h
i. Long-term Personal Care Services	☐ D1i	☐ D2i	☐ D3i	☐ D4i
j. LTC Nursing Facility	☐ D1j	☐ D2j	☐ D3j	☐ D4j
k. Other (specify) _____	☐ D1k	☐ D2k	☐ D3k	☐ D4k

VIII. Discharge Status (cont.)

E. Discharge Location Information

Enter Code

E1. Is the patient being discharged with referral for additional services?

0. **No** (*If* **No,** *skip to E7. Discharge Delay.*)
1. **Yes** (*If* **yes,** *please identify the name, location, and type of service to which the patient is discharged.)*

E2. Provider's Name

E6. Medicare Provider's Identification Number (optional)

Enter Code

E3. Provider Type

1. **Home health care** (HHA)
2. **Skilled nursing facility** (SNF/TCU)
3. **Inpatient rehabilitation hospital or unit** (IRF)
4. **Long-term care hospital** (LTCH)
5. **Psychiatric hospital or unit**
6. **Outpatient services**
7. **Short-stay acute hospital** (IPPS)
8. **Hospice**
9. **Long-term nursing facility**
10. **Other** (specify) _____

E7. Discharge Delay

Enter Code

Was the patient's discharge delayed for at least **24** hours?

0. **No**
1. **Yes**

E8. Reason for Discharge Delay

Enter Code

1. **No bed available**
2. **Services, equipment or medications not available** (e.g., home health care, durable medical equipment, IV medications)
3. **Family/support** (e.g., family could not pick patient up)
4. **Medical** (patient condition changed)
5. **Other** (specify)_____

E4. Provider City

E5. Provider State

E9. In the situation that the patient or an authorized representative has requested this information not be shared with the next provider, check here: ☐

T.VIII How long did it take you to complete the ***VIII. Discharge Status*** *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 discharge or at the time of a significant change in the patient's status affecting Medicare payment.

A. Principal Diagnosis

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

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)

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.