Proposed LTCH CARE Data Set Version 4.00 Change Table - Effective April 1, 2018

#	Item Set(s) Affected	Item / Text Affected	LTCH CARE Data Set V 3.00	Proposed LTCH CARE Data Set V 4.00 (Note: Proposed modifications to existing items highlighted in yellow)	Rationale for Change / Comments
1.	All	N/A	Version 3.00	Version 4.00	Updated version number.
2.	All	Footer	Effective April 1, 2016	Proposed LTCH CARE Data Set Version 4.00, Admission/Planned Discharge/Unplanned Discharge/Expired - Effective April 1, 2018	Updated effective date.
3.	All	N/A	N/A	Punctuation and style revisions applicable throughout the instrument	Punctuation and style revisions to be consistent with MDS and IRF-PAI.
4.	All	Section Headings and Titles	White and gray font	Black and bold font	Updated font formatting for better contrast.
5.	Planned Discharge	A2500	**A2500. Program Interruption(s)** **Program Interruptions** 0. **No** → *Skip to B0100. Comatose* 1. **Yes** → *Continue to A2510. Number of Program Interruptions During This Stay in This Facility*	N/A – delete item	Deleted to reduce provider burden.
6.	Unplanned Discharge	A2500	**A2500. Program Interruption(s)** **Program Interruptions** 0. **No** → *Skip to C1610. Signs and Symptoms of Delirium (from CAM©)* 1. **Yes** → *Continue to A2510. Number of Program Interruptions During This Stay in This Facility*	N/A – delete item	Deleted to reduce provider burden.
7.	Planned Discharge, Unplanned Discharge	A2510	**A2510. Number of Program Interruptions During This Stay in This Facility.** *Code only if A2500 equals to 1.*	N/A – delete item	Deleted to reduce provider burden.

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8.	Planned Discharge, Unplanned Discharge	A2525	**A2525. Program Interruption Dates.** *Code only if A2510 is greater than or equal to 01.* A1. First Interruption Start Date A2. First Interruption End Date B1. Second Interruption Start Date *Code only if A2510 is greater than 01.* B2. Second Interruption End Date *Code only if A2510 is greater than 01.* C1. Third Interruption Start Date *Code only if A2510 is greater than 02.* C2. Third Interruption End Date *Code only if A2510 is greater than 02.* D1. Fourth Interruption Start Date *Code only if A2510 is greater than 03.* D2. Fourth Interruption End Date *Code only if A2510 is greater than 03.* E1. Fifth Interruption Start Date *Code only if A2510 is greater than 04.* E2. Fifth Interruption End Date *Code only if A2510 is greater than 04.*	N/A – delete item	Deleted to reduce provider burden.
9.	Admission	B0200	N/A – new item	**B0200. Hearing** (3-day assessment period) **Ability to Hear** (with hearing aid or hearing appliances if normally used) 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	Added to assess Hearing in Section B – Hearing, Speech, and Vision. MDS currently assesses this but it is not present in previous versions of the LTCH CARE Data Set.

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10.	Admission	B1000	N/A – new item	**B1000. Vision** (3-day assessment period) **Ability to See in Adequate Light** (with glasses or other visual appliances) 0. **Adequate:** Sees fine detail, such as 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 in question, but eyes appear to follow objects 4. **Severely impaired**: No vision or sees only light, colors or shapes; eyes do not appear to follow objects	Added to assess Vision in Section B – Hearing, Speech, and Vision. MDS currently assesses this but it is not present in previous versions of the LTCH CARE Data Set.
11.	Admission, Planned Discharge	BB0800	**BB0800. Understanding Verbal Content** (3-day assessment period) **Understanding Verbal Content** (with hearing aid or device, if used and excluding language barriers) 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**	**BB0800. Understanding Verbal and Non-Verbal Content** (3-day assessment period) **Understanding Verbal and Non-Verbal Content** (with hearing aid or device, if used, and excluding language barriers) 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**	Added clarification that Non-Verbal Content can also be considered. Added comma for clarification.

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12.	Admission	C0100	N/A – new item	**C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?** Attempt to conduct interview with all patients. 0. **No** (patient is rarely/never understood) → *Skip to C1310, Signs and Symptoms of Delirium (from CAM ©)* 1. **Yes** → *Continue to C0200, Repetition of Three Words*	Added BIMS to Cognitive Patterns section of the LTCH CARE Data Set to assess mental status. Most public comments supportive of including BIMS. TEP supported use of BIMS. Testing supports use of MDS version of BIMS.
13.	Admission	C0200	N/A – new item	**C0200. 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 after first attempt** 0. **None** 1. **One** 2. **Two** 3. **Three** After the patient'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.	Added BIMS to Cognitive Patterns section of the LTCH CARE Data Set to assess mental status. Most public comments supportive of including BIMS. TEP supported use of BIMS. Testing supports use of MDS version of BIMS.

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14.	Admission	C0300 C0300A C0300B C0300C	N/A – new item	**C0300. Temporal Orientation** (orientation to year, month, and day) Ask patient: *"Please tell me what year it is right now."* **A. Able to report correct year** 0. **Missed by > 5 years** or no answer 1. **Missed by 2-5 years** 2. **Missed by 1 year** 3. **Correct** Ask patient: *"What month are we in right now?"* **B. Able to report correct month** 0. **Missed by > 1 month** or no answer 1. **Missed by 6 days to 1 month** 2. **Accurate within 5 days** Ask patient: *"What day of the week is today?"* **C. Able to report correct day of the week** 0. **Incorrect** or no answer 1. **Correct**	Added BIMS to Cognitive Patterns section of the LTCH CARE Data Set to assess mental status. Most public comments supportive of including BIMS. TEP supported use of BIMS. Testing supports use of MDS version of BIMS.

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15.	**Admission**	C0400 C0400A C0400B C0400C	**N/A – new item**	C0400. Recall **Ask patient: "Let's go back to an earlier 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" **0.** No - **could not recall** **1.** Yes, after cueing **("something to wear")** **2.** Yes, no cue required B. Able to recall "blue" **0.** No - **could not recall** **1.** Yes, after cueing **("a color")** **2.** Yes, no cue required C. Able to recall "bed" **0.** No - **could not recall** **1.** Yes, after cueing **("a piece of furniture")** **2.** Yes, no cue required	Added BIMS to Cognitive Patterns section of the LTCH CARE Data Set to assess mental status. Most public comments supportive of including BIMS. TEP supported use of BIMS. Testing supports use of MDS version of BIMS.
16.	Admission	C0500	N/A – new item	**C0500. BIMS Summary Score** **Add scores** for questions C0200-C0400 and fill in total score (00-15)**.** **Enter 99 if the patient was unable to complete the interview.**	Added BIMS to Cognitive Patterns section of the LTCH CARE Data Set to assess mental status. Most public comments supportive of including BIMS. TEP supported use of BIMS. Testing supports use of MDS version of BIMS.

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17.	Admission	C1310 C1310A C1310B C1310C C1310D C1610 C1610A C1610B C1610C C1610D C1610E C1610E1 C1610E2	**C1610. Signs and Symptoms of Delirium (from CAM©)** Confusion Assessment Method (CAM©) Shortened Version Worksheet (3-day assessment period) **Acute Onset and Fluctuating Course** **A.** Is there evidence of an acute change in mental status from the patient's baseline? **B.** Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity? **Inattention** **C.** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? **Disorganized Thinking** **D.** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? **Altered Level of Consciousness** **E.** Overall, how would you rate the patient's level of consciousness? **E1**. Alert (Normal) **E2.** Vigilant (hyperalert) or Lethargic (drowsy, easily aroused) or Stupor (difficult to arouse) or Coma (unarousable)	**C1310. Signs and Symptoms of Delirium (from CAM©)** Code after completing Brief Interview for Mental Status and reviewing medical record (3-day assessment period). **A. Acute Onset Mental Status Change** Is there evidence of an acute change in mental status from the patient's baseline? 0. **No** 1. **Yes** **Enter Codes in Boxes** **B. Inattention -** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? **C. Disorganized Thinking -** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? **D. Altered Level of Consciousness -** Did the patient have altered level of consciousness as indicated by any of the following criteria? • **vigilant** – startled easily to any sound or touch • **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch • **stuporous** – very difficult to arouse and keep aroused for the interview • **comatose** – could not be aroused **Coding:** 0. **Behavior not present** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	C1610 will be replaced by C1310 so that item numbers are standardized between the LTCH CARE Data Set and MDS. This data element differs from the Planned Discharge/ Unplanned Discharge data element by specifying a "3-day assessment period." TEP supportive of CAM use.

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18.	Planned Discharge, Unplanned Discharge	C1310 C1310A C1310B C1310C C1310D C1610 C1610A C1610B C1610C C1610D C1610E C1610E1 C1610E2	**C1610. Signs and Symptoms of Delirium (from CAM©)** Confusion Assessment Method (CAM©) Shortened Version Worksheet (3-day assessment period) **Acute Onset and Fluctuating Course** **A.** Is there evidence of an acute change in mental status from the patient's baseline? **B.** Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity? **Inattention** **C.** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? **Disorganized Thinking** **D.** Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject? **Altered Level of Consciousness** **E.** Overall, how would you rate the patient's level of consciousness? **E1**. Alert (Normal) **E2.** Vigilant (hyperalert) or Lethargic (drowsy, easily aroused) or Stupor (difficult to arouse) or Coma (unarousable)	**C1310. Signs and Symptoms of Delirium (from CAM©)** (within the last 7 days). **A. Acute Onset Mental Status Change** Is there evidence of an acute change in mental status from the patient's baseline? 0. **No** 1. **Yes** **Enter Codes in Boxes** **B. Inattention -** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? **C. Disorganized thinking -** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? **D. Altered level of consciousness -** Did the patient have altered level of consciousness as indicated by any of the following criteria? • **vigilant** – startled easily to any sound or touch • **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch • **stuporous** – very difficult to arouse and keep aroused for the interview • **comatose** – could not be aroused **Coding:** 0. **Behavior not present** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	C1610 will be replaced by C1310 so that item numbers are standardized between the LTCH CARE Data Set and MDS. This data element differs from the Admission version of this data element by specifying the assessment time period to be "within the last 7 days." TEP supportive of CAM use.

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19.	Admission, Planned Discharge, Unplanned Discharge	CAM © Footnote	Adapted with permission from: Inouye SK et al, Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. Annals of Internal Medicine. 1990; 113: 941-948. Confusion Assessment Method: Training Manual and Coding Guide, Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.	*Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.*	The footnote associated with C1610 will be replaced by the footnote associated with C1310.
20.	Admission, Planned Discharge	Section D	N/A – new section	**Section D. Mood**	Added new section to accommodate the Patient Health Questionnaire 2 (PHQ-2) item.

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21.	Admission, Planned Discharge	D0150 D0150A1 D0150A2 D0150B1 D0150B2	N/A – new item	**D0150. Patient Health Questionnaire 2 (PHQ-2 ©)** **Say to patient:** *"Over the last 2 weeks, have you been bothered by any of the following problems?"* If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the patient: "About how often have you been bothered by this?" Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency. **1. Symptom Presence** 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank) **2. Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day) **Enter scores in boxes** A. *Little interest or pleasure in doing things?* B. *Feeling down, depressed, or hopeless?*	Public comments supportive of using less burdensome PHQ-2 rather than PHQ-9. Suggested screening for depression symptoms to ensure that this important condition is captured as early as possible, increasing the likelihood of being able to prevent development of severe depression. TEP satisfied with reliability, validity, and utility of the PHQ-2 as a brief screener for depressive symptoms.
22.	Admission, Planned Discharge	PHQ-2 © Footnote	N/A – new footnote associated with new item	*Copyright © Pfizer Inc. All rights reserved. Reproduced with permission.*	Added footnote associated with new PHQ-2 item.
23.	Admission, Planned Discharge	Section E	N/A – new section	**Section E. Behavioral Symptoms**	Added new section to accommodate new behavioral symptoms items.

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24.	Admission, Planned Discharge	E0200 E0200A E0200B E0200C	N/A – new item	**E0200. Behavioral Symptom – Presence & Frequency** Note presence of symptoms and their frequency. **Enter Codes in Boxes** **A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). **B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others). **C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) **Coding:** 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**	Added Behavioral Symptoms to LTCH CARE Data Set. Expert input suggested that documenting the occurrence of these behaviors and their frequency would be important for care planning.

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25.	Admission	GG0100	**GG0100. Prior Functioning: Everyday Activities.** Indicate the patient's usual ability with everyday activities prior to the 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 Some Help** - Patient needed partial assistance from another person to complete activities. **1. Dependent** - A helper completed the activities for the patient. **8. Unknown** **9. Not Applicable**	**GG0100. Prior Functioning: Everyday Activities.** Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury. **Coding:** **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 partial assistance from another person to complete activities. **1. Dependent** - A helper completed the activities for the patient. **8. Unknown** **9. Not Applicable**	Added “Coding” to GG0100 instructions for consistency.
26.	Admission	GG0110	**GG0110. Prior Device Use.** Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury. Check all that apply A. Manual wheelchair B. Motorized wheelchair or scooter C. Mechanical lift Z. None of the above	**GG0110. Prior Device Use.** Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury. Check all that apply A. Manual wheelchair B. Motorized wheelchair and/or scooter C. Mechanical lift Z. None of the above	Added “and/” for clarification.

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27.	Admission	GG0130 Discharge goal coding	**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).**	**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).**	Added instructions indicating that the activity not attempted codes may be used to code goal items.
28.	Admission, Planned Discharge	GG0130 Coding options	**From 6-point scale** 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. **04**. **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.	**From 6-point scale** **05. Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. **04**. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.	Added "contact guard" and changed "or" to "and/or" for clarification in code 04. Removed capitalization from code 05.
29.	Admission, Planned Discharge	GG0130 Coding options	**If activity was not attempted, code the reason:** **07. Patient refused** **09. Not applicable** **88.** Not attempted due to **medical condition or safety concerns**	**If activity was not attempted, code the reason:** **07. Patient refused** **09. Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. **10. Not attempted due to environmental limitations** (e.g. lack of equipment, weather constraints) **88. Not attempted due to medical condition or safety concerns**	Added definition of 09 for clarification. Added new code to allow reporting of environmental limitations.

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30.	Admission, Planned Discharge	GG0130A	**A. 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.	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.	Revised wording of the item definition for clarification.
31.	Admission, Planned Discharge	GG0130B	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.	Revised wording of the item definition for clarification.
32.	Admission, Planned Discharge	GG0130C	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing equipment.	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.	Revised wording of the item definition for clarification.
33.	Admission	GG0170 Discharge goal coding	**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal(s).**	**Code the patient's usual performance at admission for each activity using the 6-point scale. If activity was not attempted at admission, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).**	Added instructions indicating that the activity not attempted codes may be used to code goal items.

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34.	Admission, Planned Discharge	GG0170 Coding option	**From 6-point scale** 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. **04**. **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.	**From 6-point scale** 05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. **04**. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.	Added "contact guard" and changed "or" to "and/or" for clarification in code 04. Removed capitalization from code 05.
35.	Admission, Planned Discharge	GG0170 Coding option	**If activity was not attempted, code the reason:** **07. Patient refused** **09. Not applicable** **88.** Not attempted due to **medical condition or safety concerns**	**If activity was not attempted, code the reason:** **07. Patient refused** **09. Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation, or injury. **10. Not attempted due to environmental limitations** (e.g. lack of equipment, weather constraints) **88. Not attempted due to medical condition or safety concerns**	Added definition of 09 for clarification. Added new code to allow reporting of environmental limitations.
36.	Admission, Planned Discharge	GG0170A	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back.	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.	Added "on the bed" for clarification.

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37.	Admission, Planned Discharge	GG0170C	**C. 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, and with no back support.	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items.
38.	Admission, Planned Discharge	GG0170D	**D. Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items. Added "wheelchair" for clarification.
39.	Admission, Planned Discharge	GG0170E	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items.
40.	Admission, Planned Discharge	GG0170F	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.	**F. Toilet transfer:** The ability to get on and off a toilet or commode.	Removed "safely." The coding instructions refer to safe performance, which applies to all self-care and mobility items.

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41.	Admission	GG0170H1	**H1. Does the patient walk?** 0. **No,** and walking goal **is not** clinically indicated → *Skip to GG0170Q1. Does the patient use a wheelchair/scooter?* 1. **No,** and walking goal **is** clinically indicated → *Code the patient's Discharge Goal(s) for items GG0170I, J, and K. For Admission Performance, skip to GG0170Q1. Does the patient use a wheelchair/ scooter?* 2. **Yes** → *Continue to GG0170I. Walk 10 feet*	N/A – delete item	The skip pattern is associated with the item Walk 10 feet.
42.	Planned Discharge	GG0170H3	**H3. Does the patient walk?** 0. **No** → *Skip to GG0170Q3. Does the patient use wheelchair/scooter?* 2. **Yes** → *Continue to GG0170I. Walk 10 feet*	N/A – delete item	The skip pattern is associated with the item Walk 10 feet.
43.	Admission	GG0170I	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170Q1, Does the patient use a wheelchair and/or scooter?*	Added skip pattern that was previously associated with GG0170H1. Added comma for clarification.
44.	Planned Discharge	GG0170I	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor or similar space.	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170Q3, Does the patient use a wheelchair and/or scooter?*	Added skip pattern that was previously associated with GG0170H3. Added comma for clarification.

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45.	Admission	GG0170Q1	**Q1. Does the patient use a wheelchair/scooter?** 0. **No** → *Skip to H0350. Bladder Continence* 1. **Yes** → *Continue to GG0170R. Wheel 50 feet with two turns*	**Q1. Does the patient use a wheelchair and/or scooter?** 0. **No** → *Skip to H0350, Bladder Continence* 1. **Yes** → *Continue to GG0170R, Wheel 50 feet with two turns*	Added for clarification.
46.	Planned Discharge	GG0170Q3	**Q3. Does the patient use a wheelchair/scooter?** 0. **No** → *Skip to H0350. Bladder Continence* 1. **Yes** → *Continue to GG0170R. Wheel 50 feet with two turns*	**Q3. Does the patient use a wheelchair and/or scooter?** 0. **No** → *Skip to H0350, Bladder Continence* 1. **Yes** → *Continue to GG0170R, Wheel 50 feet with two turns*	Added for clarification.
47.	Admission	GG0170RR1	**RR1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**	**RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**	Added for clarification.
48.	Planned Discharge	GG0170RR3	**RR3. Indicate the type of wheelchair/scooter used.** **1. Manual** **2. Motorized**	**RR3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**	Added for clarification.
49.	Admission	GG0170SS1	**SS1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**	**SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**	Added for clarification.
50.	Planned Discharge	GG0170SS3	**SS3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**	**SS3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**	Added for clarification.

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51.	Admission	I0050	**5. Other medical condition** If "other medical condition", enter the ICD code in the boxes. **I0050A.**	**5. Other medical condition** If "other medical condition," enter the ICD code in the boxes. **I0050A.**	Moved comma
52.	Admission	I0103 I0104 I0605 I5455 I5480 I7100 I7101 I7102 I7103 I7104	N/A – new items	**Comorbidities and Co-existing Conditions** **↓ Check all that apply** **I0103. Metastatic Cancer** **I0104. Severe Cancer** **I0605. Severe Left Systolic/Ventricular Dysfunction** (known ejection fraction ≤ 30%) **I5455. Other Progressive Neuromuscular Disease** **I5480. Other Severe Neurological Injury, Disease, or Dysfunction** **Post-Transplant** **I7100. Lung Transplant** **I7101. Heart Transplant** **I7102. Liver Transplant** **I7103. Kidney Transplant** **I7104. Bone Marrow Transplant**	New items added to collect data for the proposed ventilator weaning quality measures.
53.	Admission	I0101	I0101. Severe and Metastatic Cancer	N/A – delete item	I0101 will be replaced by I0103 and I0104.
54.	Planned Discharge	J1800	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)* 1. **Yes** → Continue to J1900. Number of Falls Since Admission	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to K0520, Nutritional Approaches* 1. **Yes** → Continue to J1900, Number of Falls Since Admission	Revised to correct skip pattern.

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55.	Unplanned Discharge	J1800	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to M0210. Unhealed Pressure Ulcer(s)* 1. **Yes** → Continue to J1900. Number of Falls Since Admission	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to M0210, Unhealed Pressure Ulcers/Injuries* 1. **Yes** → *Continue to J1900, Number of Falls Since Admission*	Revised to correct skip pattern.
56.	Expired	J1800	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to O0250. Influenza Vaccine* 1. **Yes** → Continue to J1900. Number of Falls Since Admission	J1800. Any Falls Since Admission Has the patient **had any falls since admission?** 0. **No** → *Skip to N2005, Medication Intervention* 1. **Yes** → *Continue to J1900, Number of Falls Since Admission*	Revised to correct skip pattern.
57.	Admission	K0520 K0520A1 K0520B1 K0520C1 K0520D1 K0520Z1	N/A – new item	**K0520. Nutritional Approaches** Check all of the following nutritional approaches that were performed during the first 3 days of admission. **1. Performed during the first 3 days of admission** **↓ Check all that apply** **A. Parenteral/IV feeding** **B. Feeding tube** – nasogastric or abdominal (e.g., PEG) **C. Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids) **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol) **Z. None of the above**	Included to align with MDS' assessment of nutritional status. Total parenteral nutrition appears in Section O of LTCH CARE Data Set V 3.00 but other nutritional approaches are not assessed, so for completeness and cross-setting standardization, item K0520 will mirror the MDS.

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58.	Planned Discharge	K0520 K0520A2 K0520B2 K0520C2 K0520D2 K0520Z2	N/A – new item	**K0520. Nutritional Approaches** Check all of the following nutritional approaches that were performed during the last 7 days. **2. Performed during the last 7 days** **↓ Check all that apply** **A. Parenteral/IV feeding** **B. Feeding tube –** nasogastric or abdominal (e.g., PEG) **C. Mechanically altered diet –** require change in texture of food or liquids (e.g., pureed food, thickened liquids) **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol) **Z. None of the above**	Included to align with MDS' assessment of nutritional status. Total parenteral nutrition appears in Section O of LTCH CARE Data Set V 3.00 but other nutritional approaches are not assessed, so for completeness and cross-setting standardization, "Total parental nutrition" will be moved from Section O and renamed "Parenteral/IV feeding" to become a response option in the new item K0520, which will mirror the MDS.
59.	Admission, Planned Discharge, Unplanned Discharge	Section M heading	**Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage**	**Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage**	Added the term "injuries" to be inclusive of updated terminology supported by the National Pressure Ulcer Advisory Panel (NPUAP).

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60.	Admission	M0210	**M0210. Unhealed Pressure Ulcer(s) Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → *Skip to O0100. Special Treatments, Procedures, and Programs* 1. **Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*	**M0210. Unhealed Pressure Ulcers/Injuries Does this patient have one or more unhealed pressure ulcers/injuries?** 0. **No** → *Skip to N2001, Drug Regimen Review* 1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*	Deleted text to clarify. Added the term "injury" to be inclusive of updated terminology supported by NPUAP.
61.	Planned Discharge, Unplanned Discharge	M0210	**M0210. Unhealed Pressure Ulcer(s) Does this patient have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → *Skip to O0100. Special Treatments, Procedures, and Programs* 1. **Yes** → *Continue to M0300. Current Number of Unhealed Pressure Ulcers at Each Stage*	**M0210. Unhealed Pressure Ulcers/Injuries Does this patient have one or more unhealed pressure ulcers/injuries?** 0. **No** → *Skip to N2005, Medication Intervention* 1. **Yes** → *Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage*	Deleted text to clarify. Added the term "injuries" to be inclusive of updated terminology supported by NPUAP.
62.	Admission, Planned Discharge, Unplanned Discharge	M0300	**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage**	**M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage**	Added the term "injuries" to be inclusive of updated terminology supported by NPUAP.
63.	Admission, Planned Discharge, Unplanned Discharge	M0300A	**Number of Stage 1 pressure ulcers**	1. **Number of Stage 1 pressure injuries**	Added the number one to be consistent with other items in the section. Replaced the term "ulcers" with "injuries" as the term "injuries" indicates intact skin which better aligns with criteria for Stage 1.

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64.	Planned Discharge, Unplanned Discharge	M0300D1	**D1. Number of Stage 4 pressure ulcers** - If 0 → *Skip to M0300E. Unstageable - Non-removable dressing*	**D1. Number of Stage 4 pressure ulcers** - If 0 → *Skip to M0300E, Unstageable - Non-removable dressing/device*	Added the word "device" for clarity.
65.	Admission	M0300E M0300E1	**E. Unstageable - Non-removable dressing:** Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers due to non-removable dressing/device**	**E. Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device**	Added the word "device" for clarity. Added the term "injuries" to be inclusive of updated terminology supported by NPUAP.
66.	Planned Discharge, Unplanned Discharge	M0300E M0300E2	**E. Unstageable - Non-removable dressing:** Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers due to non-removable dressing/device -** *If 0 →Skip to M0300F. Unstageable - Slough and/or eschar* **2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission -** enter how many were noted at the time of admission	**E. Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device -** *If 0 → Skip to M0300F, Unstageable - Slough and/or eschar* **2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission -** enter how many were noted at the time of admission	Added the word "device" for clarity. Added the term "injuries" to be inclusive of updated terminology supported by NPUAP.
67.	Admission	M0300G M0300G1	**G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution. 1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable pressure injuries presenting as deep tissue injury**	Removed the term "suspected deep tissue injury in evolution" and replaced with "deep tissue injury" to be consistent with updated NPUAP terminology.

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68.	Planned Discharge, Unplanned Discharge	M0300G M0300G1 M0300G2	**G. Unstageable - Deep tissue injury:** Suspected deep tissue injury in evolution. 1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 →*Skip to M0800. Worsening in Pressure Ulcer Status Since Admission* 2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission** - enter how many were noted at the time of admission	**G. Unstageable - Deep tissue injury** 1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → *Skip to N2005, Medication Intervention* 2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission** - enter how many were noted at the time of admission	Removed the term "suspected deep tissue injury in evolution" and replaced with "deep tissue injury" to be consistent with updated NPUAP terminology.
69.	Planned Discharge, Unplanned Discharge	M0800	**M0800. Worsening in Pressure Ulcer Status Since Admission** Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on admission. If no current pressure ulcer at a given stage, enter 0 **A. Stage 2** **B. Stage 3** **C. Stage 4** **D. Unstageable - Non-removable dressing** **E. Unstageable - Slough and/or eschar** **F. Unstageable - Deep tissue injury**	N/A – delete items	Deleted to reduce provider burden.

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70.	Admission, Planned Discharge, Unplanned Discharge, Expired	Section N	N/A – new section	**Section N. Medications**	New section added on admission and discharge to accommodate the drug regimen review quality measure items N2001, N2003, and N2005.
71.	Admission	N2001	N/A – new item	N2001. Drug Regimen Review Did a complete drug regimen review identify potential clinically significant medication issues? 0. **No - No issues found during review** → *Skip to O0100, Special Treatments, Procedures, and Programs* 1. **Yes - Issues found during review** → *Continue to N2003, Medication Follow-up* 9. **NA - Patient is not taking any medications**→ *Skip to O0100, Special Treatments, Procedures, and Programs*	New items added to collect data for the drug regimen review quality measure.
72.	Admission	N2003	N/A – new item	**N2003. Medication Follow-up** **Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ recommended actions in response to the identified potential clinically significant medication issues?** 0. **No** 1. **Yes**	New item added to collect data for the drug regimen review quality measure.

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73.	Planned Discharge, Unplanned Discharge, Expired	N2005	N/A – new item	**N2005. Medication Intervention** **Did the facility contact and complete physician (or physician-designee) prescribed/ recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?** 0. **No** 1. **Yes** 9. **NA - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications**	New item added to collect data for the drug regimen review quality measure.
74.	Admission	O0100F3 O0100F4	O0100F3. Invasive Mechanical Ventilator: weaning O0100F4. Invasive Mechanical Ventilator: non-weaning	N/A – delete items	Invasive mechanical ventilation, whether weaning or non-weaning will now be assessed using data collected as part of the proposed ventilator weaning quality measures (including O0150 and O0200).

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75.	Admission	O0100	**O0100. Special Treatments, Procedures, and Programs** Check all the treatments at admission. For dialysis, check if it is part of the patient's treatment plan.	**O0100. Special Treatments, Procedures, and Programs** Check all of the following treatments, procedures, and programs that were performed during the first 3 days of admission. For chemotherapy and dialysis, check if it is part of the patient's treatment plan. **3. Performed during the first 3 days of admission** **↓ Check all that apply**	The assessment time period was changed for internal consistency within the rest of the LTCH CARE Data Set.
76.	Planned Discharge, Unplanned Discharge	O0100	N/A – new item	**O0100. Special Treatments, Procedures, and Programs** Check all of the following treatments, procedures, and programs that were performed during the last 14 days. **4. Performed during the last 14 days** **↓ Check all that apply**	The 14-day assessment time period was chosen to achieve standardization with the MDS' 14-day assessment time period.
77.	Admission, Planned Discharge (Note: '3' denotes admission and '4' denotes discharge)	O0100A3 O0100A4 O0100A2a3 O0100A2a4 O0100A3a3 O0100A3a4 O0100A10a3 O0100A10a4	N/A – new item	**A. Chemotherapy** (if checked, please specify below) A2a. IV A3a. Oral A10a. Other	Included to respond to public comment and subject matter experts support breaking the parent item "chemotherapy" into type of chemotherapy to distinguish patient complexity/burden of care.

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78.	Admission, Planned Discharge	O0100B3 O0100B4	N/A – new item	**B. Radiation**	Included to align with the MDS.
79.	Admission, Planned Discharge	O0100C3 O0100C4 O0100C2a3 O0100C2a4 O0100C3a3 O0100C3a4	N/A – new item	**C. Oxygen Therapy** (if checked, please specify below) C2a. Continuous C3a. Intermittent	Included to respond to public comment and subject matter experts support breaking the parent item "oxygen therapy" into continuous or intermittent to distinguish patient complexity/burden of care.
80.	Admission, Planned Discharge, Unplanned Discharge	O0100D3 O0100D4 O0100D2a3 O0100D2a4 O0100D3a3 O0100D3a4	N/A – new item	**D. Suctioning** (if checked, please specify below) D2a. Scheduled D3a. As needed	Included to respond to and public comment and subject matter experts support breaking the parent item "suctioning" into frequency of suctioning to distinguish patient complexity/ burden of care.
81.	Admission, Planned Discharge, Unplanned Discharge	O0100E3 O0100E4	N/A – new item	**E. Tracheostomy Care**	Included for cross-setting standardization with the MDS.
82.	Admission, Planned Discharge	O0100G3 O0100G4 O0100G2a3 O0100G2a4 O0100G3a3 O0100G3a4	Admission: G. Non-invasive Ventilator (BIPAP, CPAP) Planned Discharge: N/A – new item	**G. Non-invasive Mechanical Ventilator (BiPAP/CPAP)** (if checked, please specify below) G2a. BiPAP G3a. CPAP	In public comment, there was support for breaking the parent item into 2 response options (BiPAP and CPAP).

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83.	Admission, Planned Discharge	O0100H3 O0100H4 O0100H2a3 O0100H2a4 O0100H3a3 O0100H3a4 O0100H4a3 O0100H4a4 O0100H10a3 O0100H10a4	N/A – new item	**H. IV Medications** (if checked, please specify below) H2a. Vasoactive medications (i.e., continuous infusions of vasopressors or inotropes) H3a. Antibiotics H4a. Anticoagulation H10a. Other	In public comment, there was support for further delineating types of IV medications (and the new vasoactive medication item, O0100H2a, is included for the proposed ventilator weaning quality measures).
84.	Admission, Planned Discharge	O0100I3 O0100I4	N/A – new item	**I. Transfusions**	Included for cross-setting standardization with the MDS.
85.	Admission, Planned Discharge	O0100J3 O0100J4 O0100J2a3 O0100J2a4 O0100J3a3 O0100J3a4	Admission: J. Dialysis Planned Discharge: N/A – new item	**J. Dialysis** (if checked, please specify below) J2a. Hemodialysis J3a. Peritoneal dialysis	Item added to Planned Discharge. In public comment, there was support for breaking out the parent item “dialysis” into type of dialysis. New dialysis items also added to collect data for the proposed ventilator weaning quality measures.
86.	Admission	O0100N	O0100N. Total Parenteral Nutrition	N/A – delete O0100N	Total parental nutrition will be assessed as part of new item in Section K, K0520, to align with the MDS.

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87.	Admission, Planned Discharge	O0100O3 O0100O4 O0100O2a3 O0100O2a4 O0100O3a3 O0100O3a4 O0100O4a3 O0100O4a4 O0100O10a3 O0100O10a4	N/A – new item	**O. IV Access** (if checked, please specify below) O2a. Peripheral IV O3a. Midline O4a. Central line (e.g., PICC, tunneled, port) O10a. Other	In public comment, there was support for breaking out the parent item (which appears on the MDS) into types of IV access.
88.	Planned Discharge, Unplanned Discharge	O0100Z3 O0100Z4	Planned Discharge: N/A- new item Unplanned Discharge: N/A- new item	**Z. None of the above**	Item added to Planned Discharge and Unplanned Discharge.
89.	Admission	O0150 O0150A O0150B O0150C O0150D O0150E	N/A – new items	**O0150. Spontaneous Breathing Trial (SBT)** (including Tracheostomy Collar (TCT) or Continuous Positive Airway Pressure (CPAP) Breathing Trial) **by Day 2 of LTCH Stay** **A. Invasive Mechanical Ventilation Support upon Admission to the LTCH** 0. **No, not on invasive mechanical ventilation support** → *Skip to O0250, Influenza Vaccine* 1. **Yes, weaning** → *Continue to O0150B, Assessed for readiness for SBT by Day 2 of the LTCH stay* 2. **Yes, non-weaning** → *Skip to O0250, Influenza Vaccine* *(continued)*	New items added to collect data for the proposed ventilator weaning quality measures.

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				B. Assessed for readiness for SBT by day 2 of the LTCH stay (Note: Day 2=Date of Admission to the LTCH (Day 1) + 1 calendar day) 0. **No** → *Skip to O0250, Influenza Vaccine* 1. **Yes** → *Continue to O0150C, Deemed medically ready for SBT by Day 2 of the LTCH stay* **C. Deemed medically ready for SBT by day 2 of the LTCH stay** 0. **No** → *Continue to O0150D, Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?* 1. **Yes** → *Continue to O0150E, SBT performed by day 2 of the LTCH stay* **D. Is there documentation of reason(s) in the patient's medical record that the patient was deemed medically unready for SBT by day 2 of the LTCH stay?** 0. **No** → *Skip to O0250, Influenza Vaccine* 1. **Yes** → *Skip to O0250, Influenza Vaccine* **E. SBT performed by day 2 of the LTCH stay** 0. **No** 1. **Yes**	

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90.	Planned Discharge, Unplanned Discharge	O0200 O0200A	N/A – new items	**O0200. Ventilator Liberation Rate** **A. Invasive Mechanical Ventilator: Liberation Status at Discharge** **0. Not fully liberated at discharge** (i.e., patient required partial or full invasive mechanical ventilation support within 2 calendar days prior to discharge) **1. Fully liberated at discharge** (i.e., patient did not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge) **9. NA** (code only if the patient was non-weaning or not ventilated on admission [O0150A=2 or 0 on Admission Assessment])	New items added to collect data for the proposed ventilator weaning quality measures.