

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

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

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

| | |
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| B1000. Vision | |
| Enter Code <input type="text"/> | <p>Ability to see in adequate light (with glasses or other visual appliances)</p> <ul style="list-style-type: none"> 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 |

B1300. Health Literacy

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code

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

Section C

Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200 -C0500) be Conducted?

Attempt to conduct interview with all patients.

Enter Code

- 0. No (patient is rarely/never understood) → Skip to XXXX
- 1. Yes → Continue to C0200, Repetition of Three Words

~~XXXXXX~~

~~XXXXXX~~

?

Enter Code

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."

~~XXXXXX~~

?

- 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.

~~XXXXXX~~

(orientation to year, month, and day)

Enter Code

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

Enter Code

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

Enter Code

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

| C0400. Recall | |
|--|---|
| Enter Code <input type="checkbox"/> | 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 |
| Enter Code <input type="checkbox"/> | B. Able to recall blue 0. No- could not recall 1. Yes, after cueing ("a color") 2. Yes, no cue required |
| Enter Code <input type="checkbox"/> | C. Able to recall bed 0. No- could not recall 1. Yes, after cueing ("a piece of furniture") 2. Yes, no cue required |
| C0500. BIMS Summary Score | |
| Enter Score <input type="text"/> | Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if the patient was unable to complete the interview |

| C1310. Signs and Symptoms of Delirium (from CAM ©) | |
|---|---|
| Code after completing Brief Interview for Mental Status and reviewing medical record. | |
| A. Acute Onset Mental Status Change | |
| Enter Code <input type="checkbox"/> | Is there evidence of an acute change in mental status from the patient's baseline? 0. No 1. Yes |
| Coding: 0. Z À % Œ • í X Z À } v š] v % Œ • v } š ž p í X Z À (o μ (comes μ and goes, changes in severity) | ↓ Enter Code in Boxes |
| | <input type="checkbox"/> B. Inattention - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said? |
| | <input type="checkbox"/> C. Disorganized thinking - Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? |
| | <input type="checkbox"/> D. Altered level of consciousness - Did the patient have altered level of consciousness as indicated by any of the following criteria? <ul style="list-style-type: none"> ▪ - startled easily to any sound or touch ▪ - repeatedly dozed off when being asked questions, but responded to voice or touch ▪ - very difficult to arouse and keep aroused for the interview ▪ - could not be aroused |
| <i>Confusion Assessment Method. © 1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.</i> | |

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

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

| 1. Symptom Presence 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) | 1. Symptom Presence | 2. Symptom Frequency |
|---|--|--------------------------|-------------------------|
| | | ↓Enter Scores in Boxes ↓ | |

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

| | | |
|-------------|---|---|
| Enter Score | <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> | , Symptom Frequency. Total score must be between 02 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items) |
|-------------|---|---|

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|---|--|
| D0700. Social Isolation | |
| How often do you feel lonely or isolated from those around you? | |
| Enter Code <input type="text"/> | 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 8. Patient unable to respond |

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| Section GG | Functional Abilities and Goals |
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| GG0170. Mobility (3-day assessment period) |
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| | | |
|--------------------------------|-------------------------|---|
| 1. Admission Performance | 2. Discharge Goal | |
| <input type="text"/> | <input type="text"/> | The ability to get on and off a toilet or commode. <i>If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170I, Walk 10 feet</i> |

| | | |
|--------------------------------|-------------------------|--|
| 1. Admission Performance | 2. Discharge Goal | |
| <input type="text"/> | <input type="text"/> | Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. <i>If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)</i> |

| | | |
|--------------------------------|-------------------------|--|
| 1. Admission Performance | 2. Discharge Goal | |
| <input type="text"/> | <input type="text"/> | The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt. |

| | | |
|--------------------------------|-------------------------|--|
| 1. Admission Performance | 2. Discharge Goal | |
| <input type="text"/> | <input type="text"/> | The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. |

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| Section K | Swallowing/Nutritional Status |
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| K0520. Nutritional Approaches | |
|--|---------------------------|
| Check all of the following nutritional approaches that apply on admission. | |
| | 1. On Admission |
| | Check all that apply ↓ |
| A. Parenteral/IV feeding | <input type="checkbox"/> |
| B. Feeding tube (e.g., nasogastric or abdominal (PEG)) | <input type="checkbox"/> |
| C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids) | <input type="checkbox"/> |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | <input type="checkbox"/> |
| . None of the above | <input type="checkbox"/> |

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

| N0415. High-Risk Drug Classes: Use and Indication | | |
|--|---------------------------|---------------------------|
| 1. Is taking Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes 2. Indication noted If column 1 is checked, check if there is an indication noted for all medications in the drug class | 1. Is taking | 2. Indication noted |
| | Check all that apply ↓ | Check all that apply ↓ |
| A. Antipsychotic | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Anticoagulant | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Antibiotic | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Opioid | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Antiplatelet | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Hypoglycemic (including insulin) | <input type="checkbox"/> | <input type="checkbox"/> |
| . None of the above | <input type="checkbox"/> | |

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

| | a. On Admission Check all that apply ↓ |
|--|---|
| Cancer Treatments | |
| A1. Chemotherapy | <input type="checkbox"/> |
| A2. IV | <input type="checkbox"/> |
| A3. Oral | <input type="checkbox"/> |
| A10. Other | <input type="checkbox"/> |
| B1. Radiation | <input type="checkbox"/> |
| Respiratory Therapies | |
| C1. Oxygen Therapy | <input type="checkbox"/> |
| C2. Continuous | <input type="checkbox"/> |
| C3. Intermittent | <input type="checkbox"/> |
| C4. High-concentration | <input type="checkbox"/> |
| D1. Suctioning | <input type="checkbox"/> |
| D2. Scheduled | <input type="checkbox"/> |
| D3. As Needed | <input type="checkbox"/> |
| E1. Tracheostomy care | <input type="checkbox"/> |
| G1. Non-Invasive Mechanical Ventilator | <input type="checkbox"/> |
| G2. BiPAP | <input type="checkbox"/> |
| G3. CPAP | <input type="checkbox"/> |
| Other | |
| H1. IV Medications | <input type="checkbox"/> |
| H2. Vasoactive medications | <input type="checkbox"/> |
| H3. Antibiotics | <input type="checkbox"/> |
| H4. Anticoagulation | <input type="checkbox"/> |
| H10. Other | <input type="checkbox"/> |
| I1. Transfusions | <input type="checkbox"/> |

| 00110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply on admission. | |
|---|---|
| | a. On Admission Check all that apply ↓ |
| J1. Dialysis | <input type="checkbox"/> |
| J2. Hemodialysis | <input type="checkbox"/> |
| J3. Peritoneal dialysis | <input type="checkbox"/> |
| O1. IV Access | <input type="checkbox"/> |
| O2. Peripheral | <input type="checkbox"/> |
| O3. Midline | <input type="checkbox"/> |
| O4. Central (e.g., PICC, tunneled, port) | <input type="checkbox"/> |
| None of the Above | |
| 1. None of the above | <input type="checkbox"/> |

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

Enter Code

E. If the patient was deemed medically ready for SBT, was SBT performed by day 2 of the LTCH stay?

0. No

1.

PLANNED DISCHARGE

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| Section A | Administrative Information |
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A1250. Transportation

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

↓ Check all that apply

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

A2105. Discharge Location

Enter Code

| | |
|--|--|
| | |
|--|--|

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

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

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

Enter Code

| |
|--|
| |
|--|

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

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

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

| | |
|--|---|
| A2123. Provision of Current Reconciled Medication List to Patient at Discharge At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver? | |
| Enter Code <input type="checkbox"/> | 0. No – Current reconciled medication list not provided to the patient, family and/or caregiver 1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver |

| | |
|---|---------------------------|
| A2124. Route of Current Reconciled Medication List Transmission to Patient Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver. | |
| Route of Transmission | Check all that apply ↓ |
| A. Electronic Health Record (e.g., electronic access to patient portal) | <input type="checkbox"/> |
| B. Health Information Exchange Organization | <input type="checkbox"/> |
| C. Verbal (e.g., in-person, telephone, video conferencing) | <input type="checkbox"/> |
| D. Paper-based (e.g., fax, copies, printouts) | <input type="checkbox"/> |
| E. Other Methods (e.g., texting, email, CDs) | <input type="checkbox"/> |

| | |
|------------------|------------------------------------|
| Section B | Hearing, Speech, and Vision |
|------------------|------------------------------------|

| | |
|--|--|
| B1300. Health Literacy How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? | |
| Enter Code <input type="checkbox"/> | 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 8. Patient unable to respond |

| | |
|-----------|--|
| Section O | Special Treatments, Procedures, and Programs |
|-----------|--|

| | |
|--|---------------------------|
| O0110. Special Treatments, Procedures, and Programs | |
| Check all of the following treatments, procedures, and programs that apply at discharge. | |
| | c. At Discharge |
| | Check all that apply ↓ |
| Cancer Treatments | |
| A1. Chemotherapy | <input type="checkbox"/> |
| A2. IV | <input type="checkbox"/> |
| A3. Oral | <input type="checkbox"/> |
| A10. Other | <input type="checkbox"/> |
| B1. Radiation | <input type="checkbox"/> |
| Respiratory Therapies | |
| C1. Oxygen Therapy | <input type="checkbox"/> |
| C2. Continuous | <input type="checkbox"/> |
| C3. Intermittent | <input type="checkbox"/> |
| C4. High-concentration | <input type="checkbox"/> |
| D1. Suctioning | <input type="checkbox"/> |
| D2. Scheduled | <input type="checkbox"/> |
| D3. As Needed | <input type="checkbox"/> |
| E1. Tracheostomy care | <input type="checkbox"/> |
| F1. Invasive Mechanical Ventilator (ventilator or respirator) | <input type="checkbox"/> |
| G1. Non-Invasive Mechanical Ventilator | <input type="checkbox"/> |
| G2. BiPAP | <input type="checkbox"/> |
| G3. CPAP | <input type="checkbox"/> |
| Other | |
| H1. IV Medications | <input type="checkbox"/> |
| H2. Vasoactive medications | <input type="checkbox"/> |
| H3. Antibiotics | <input type="checkbox"/> |
| H4. Anticoagulation | <input type="checkbox"/> |
| H10. Other | <input type="checkbox"/> |

| O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply at discharge. | |
|---|---|
| | c. At Discharge Check all that apply ↓ |
| I1. Transfusions | <input type="checkbox"/> |
| J1. Dialysis | <input type="checkbox"/> |
| J2. Hemodialysis | <input type="checkbox"/> |
| J3. Peritoneal dialysis | <input type="checkbox"/> |
| O1. IV Access | <input type="checkbox"/> |
| O2. Peripheral | <input type="checkbox"/> |
| O3. Midline | <input type="checkbox"/> |
| O4. Central (e.g., PICC, tunneled, port) | <input type="checkbox"/> |
| None of the Above | |
| 1. None of the above | <input type="checkbox"/> |

| O0200. Ventilator Liberation Rate (Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge) | |
|---|---|
| Enter Code <input type="checkbox"/> | A. Invasive Mechanical Ventilator: Liberation Status at Discharge 0. Not fully liberated at discharge (i.e., patient required partial or full invasive mechanical ventilation support within 2 calendar days prior to discharge) 1. Fully liberated at discharge (i.e., patient did not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge) 9. Not applicable (code only if the patient was not on invasive mechanical ventilator support upon <u>admission</u> [O0150A = 0] or the patient was determined to be non-weaning upon <u>admission</u> [O0150A2 = 0]) |

NPLANNED DISCHARGE

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| Section A | Administrative Information |
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A1990. Patient Discharged Against Medical Advice?

Enter Code

- 0. No
- 1. Yes

A2105. Discharge Location

Enter Code

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

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

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

Enter Code

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

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

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

| | |
|---|---|
| A2123. Provision of Current Reconciled Medication List to Patient at Discharge | |
| At the time of discharge, did your facility provide the patient's current reconciled medication list to the patient, family and/or caregiver? | |
| Enter Code <input type="checkbox"/> | 0. No – Current reconciled medication list not provided to the patient, family and/or caregiver 1. Yes – Current reconciled medication list provided to the patient, family and/or caregiver |

| | |
|--|---------------------------|
| A2124. Route of Current Reconciled Medication List Transmission to Patient | |
| Indicate the route(s) of transmission of the current reconciled medication list to the patient/family/caregiver. | |
| Route of Transmission | Check all that apply ↓ |
| A. Electronic Health Record (e.g., electronic access to patient portal) | <input type="checkbox"/> |
| B. Health Information Exchange Organization | <input type="checkbox"/> |
| C. Verbal (e.g., in-person, telephone, video conferencing) | <input type="checkbox"/> |
| D. Paper-based (e.g., fax, copies, printouts) | <input type="checkbox"/> |
| E. Other Methods (e.g., texting, email, CDs) | <input type="checkbox"/> |

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

| | | | |
|--|--|---|---|
| C1310. Signs and Symptoms of Delirium (from CAM ©) | | | |
| Code after reviewing medical record. | | | |
| A. Acute Onset Mental Status Change | | | |
| Enter Code <input type="checkbox"/> | from the patient's baseline? | | |
| <input type="checkbox"/> E } i X Z À %o CE • i X Z À } v š] v %o CE • v } š (o i X Z À (o μ (comes μ and goes, changes in severity) | <table border="1"> <tr> <td>↓ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> <td> <input type="checkbox"/> - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said? <input type="checkbox"/> - Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? <input type="checkbox"/> - Did the patient have altered level of consciousness as indicated by any of the following criteria? <input type="checkbox"/> - Startled easily by any sound or touch <input type="checkbox"/> - Repeatedly dozed off when being asked questions, but responded to voice or touch <input type="checkbox"/> - Very difficult to arouse and keep aroused for the interview <input type="checkbox"/> - Could not be aroused </td> </tr> </table> | ↓ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> - Did the patient have difficulty focusing attention, for example being easily distractible or having difficulty keeping track of what was being said? <input type="checkbox"/> - Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? <input type="checkbox"/> - Did the patient have altered level of consciousness as indicated by any of the following criteria? <input type="checkbox"/> - Startled easily by any sound or touch <input type="checkbox"/> - Repeatedly dozed off when being asked questions, but responded to voice or touch <input type="checkbox"/> - Very difficult to arouse and keep aroused for the interview <input type="checkbox"/> - Could not be aroused |
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| 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. | | | |

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

| K0520. Nutritional Approaches | | |
|---|---------------------------|---------------------------|
| 4. Last 7 Days Check all of the nutritional approaches that were received in the last 7 days 5. At Discharge Check all of the nutritional approaches that were being received at discharge | 4. Last 7 Days | 5. At Discharge |
| | Check all that apply ↓ | Check all that apply ↓ |
| A. Parenteral/IV feeding | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Feeding tube (e.g., nasogastric or abdominal (PEG)) | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | <input type="checkbox"/> | <input type="checkbox"/> |
| . None of the above | <input type="checkbox"/> | <input type="checkbox"/> |

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

| N0415. High-Risk Drug Classes: Use and Indication | | |
|--|---------------------------|---------------------------|
| 1. Is taking Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes 2. Indication noted If column 1 is checked, check if there is an indication noted for all medications in the drug class | 1. Is taking | 2. Indication noted |
| | Check all that apply ↓ | Check all that apply ↓ |
| A. Antipsychotic | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Anticoagulant | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Antibiotic | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Opioid | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Antiplatelet | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Hypoglycemic (including insulin) | <input type="checkbox"/> | <input type="checkbox"/> |
| . None of the above | <input type="checkbox"/> | |

| | |
|-----------|--|
| Section O | Special Treatments, Procedures, and Programs |
|-----------|--|

| | |
|--|---------------------------|
| O0110. Special Treatments, Procedures, and Programs | |
| Check all of the following treatments, procedures, and programs that apply at discharge. | |
| | c. At Discharge |
| | Check all that apply ↓ |
| Cancer Treatments | |
| A1. Chemotherapy | <input type="checkbox"/> |
| A2. IV | <input type="checkbox"/> |
| A3. Oral | <input type="checkbox"/> |
| A10. Other | <input type="checkbox"/> |
| B1. Radiation | <input type="checkbox"/> |
| Respiratory Therapies | |
| C1. Oxygen Therapy | <input type="checkbox"/> |
| C2. Continuous | <input type="checkbox"/> |
| C3. Intermittent | <input type="checkbox"/> |
| C4. High-concentration | <input type="checkbox"/> |
| D1. Suctioning | <input type="checkbox"/> |
| D2. Scheduled | <input type="checkbox"/> |
| D3. As Needed | <input type="checkbox"/> |
| E1. Tracheostomy care | <input type="checkbox"/> |
| F1. Invasive Mechanical Ventilator (ventilator or respirator) | <input type="checkbox"/> |
| G1. Non-Invasive Mechanical Ventilator | <input type="checkbox"/> |
| G2. BiPAP | <input type="checkbox"/> |
| G3. CPAP | <input type="checkbox"/> |
| Other | |
| H1. IV Medications | <input type="checkbox"/> |
| H2. Vasoactive medications | <input type="checkbox"/> |
| H3. Antibiotics | <input type="checkbox"/> |
| H4. Anticoagulation | <input type="checkbox"/> |
| H10. Other | <input type="checkbox"/> |

| O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply at discharge. | |
|---|---|
| | c. At Discharge Check all that apply ↓ |
| I1. Transfusions | <input type="checkbox"/> |
| J1. Dialysis | <input type="checkbox"/> |
| J2. Hemodialysis | <input type="checkbox"/> |
| J3. Peritoneal dialysis | <input type="checkbox"/> |
| O1. IV Access | <input type="checkbox"/> |
| O2. Peripheral | <input type="checkbox"/> |
| O3. Midline | <input type="checkbox"/> |
| O4. Central (e.g., PICC, tunneled, port) | <input type="checkbox"/> |
| None of the Above | |
| 1. None of the above | <input type="checkbox"/> |

| O0200. Ventilator Liberation Rate (Note: 2 calendar days prior to discharge = 2 calendar days + day of discharge) | |
|---|---|
| Enter Code <input type="checkbox"/> | A. Invasive Mechanical Ventilator: Liberation Status at Discharge 0. Not fully liberated at discharge (i.e., patient required partial or full invasive mechanical ventilation support within 2 calendar days prior to discharge) 1. Fully liberated at discharge (i.e., patient did not require any invasive mechanical ventilation support for at least 2 consecutive calendar days immediately prior to discharge) 9. Not applicable (code only if the patient was not on invasive mechanical ventilator support upon <u>admission</u> [O0150A = 0] or the patient was determined to be non-weaning upon <u>admission</u> [O0150A2 = 0]) |