Care Area Assessments (CAAs) & Care Planning

Section V

Item V0100
Items From the Most Recent Prior OBRA or PPS Assessment
**V0100 Guidelines**

- Values are derived from a prior OBRA or scheduled PPS assessment performed since the most recent admission of any kind (i.e., since the most recent entry or reentry), if one is available.
  - A0310E is coded **0. No.**
- Skip V0100A, B, C, D, E and F on the first assessment (OBRA or PPS) following the most recent admission of any kind.
  - A0310E is coded **1. Yes.**

**V0100 Guidelines**

- Complete V0100 only if:
  - A prior assessment has been completed since the most recent admission to the facility.
  - The prior assessment was a Federal OBRA assessment OR a PPS assessment.
  - Prior discharge or entry records are not considered or included in this list.

**V0100A & V0100B Coding**

- V0100A and V0100B cannot both be **99**.
- Complete this item for the most recent prior OBRA or PPS assessment only.
V0100C Coding Instructions

- Record the value of A2300 Assessment Reference Date from the most recent prior OBRA or scheduled PPS assessment.

<table>
<thead>
<tr>
<th>Observation end date:</th>
<th>1 5 6 2 0 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Months</td>
<td>Date</td>
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</tbody>
</table>

Item V0100C for the current assessment

Minimum Data Set (MDS) 3.0  Section V  June 2010  7

V0100D Coding Instructions

- Record the value for C0500 from the most recent prior OBRA or scheduled PPS assessment.
- Used to evaluate resident improvement or decline in the Delirium care area.

<table>
<thead>
<tr>
<th>Observation end date:</th>
<th>C0500 value from prior assessment</th>
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<tbody>
<tr>
<td>Months</td>
<td>Date</td>
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Item V0100D for the current assessment

Minimum Data Set (MDS) 3.0  Section V  June 2010  8

V0100E Coding Instructions

- Record the value for D0300 from the most recent prior OBRA or scheduled PPS assessment.
- Used to evaluate resident decline in Mood State care area.

<table>
<thead>
<tr>
<th>Observation end date:</th>
<th>D0300 value from prior assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Months</td>
<td>Date</td>
</tr>
</tbody>
</table>

Item V0100E for the current assessment

Minimum Data Set (MDS) 3.0  Section V  June 2010  9
V0100F Coding Instructions

- Record the value for D0600 from the most recent prior OBRA or scheduled PPS assessment.
- Used to evaluate resident decline in the Mood State care area.

Item V0100F for the current assessment

D0600 Total Severity Score
Add scores for all frequency responses in Column 2. Symptom Frequency. Total score must be between 0 and 3.

Item D0600 from the most recent prior assessment

V0200 CAAs and Care Planning

- Documents:
  - Which care areas triggered and require further assessment
  - Whether or not a care area is addressed in the resident care plan
  - Location and date of CAA information
- Reflects the IDT and resident’s decisions on which triggered conditions will be addressed in the care plan.
V0200A Column A Care Area Triggered Coding Instructions

- Facility uses the RAI triggering mechanism to determine which problem care areas require review and additional assessment.
- Triggered care areas are checked in Column A.

V0200A Column B Addressed In Care Plan Coding Instructions

- Check Column B to indicate a decision to develop a new care plan, revise a care plan, or continue a current care plan to address the problem(s) identified.
- Must be completed within 7 days of completing the RAI.

V0200 Location and Date of CAA Information Coding Instructions

- Indicate date and location of the CAA documentation.
Minimum Data Set (MDS) 3.0

Section V

June 2010

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V0200B Signature of RN Coordinator & Date Signed Coding Instructions

- V0200B1: Signature of the RN coordinating the CAA process.
- V0200B2: Date that the RN coordinating the CAA process certifies that the CAAs have been completed.

V0200C Care Plan Decision Signature & Date

- V0200C1: Signature of staff person facilitating care planning decision-making.
- V0200C2: Date on which a staff member completes the care planning decision column, which is done after the care plan is completed.

Care Area Assessments
The Triggers

• A Care Area Trigger (CAT) - MDS response indicating that clinical factors exist that may or may not represent a condition that should be care planned.

• When a resident’s status on a particular MDS item matches one of the CATs → the related care area is triggered for further assessment.

• Triggers flag conditions that warrant further investigation.

• Trigger Legend in Chapter 4 lists the triggers.

The Triggers

• A care area may be triggered by:
  o A single MDS response option
  o A combination of more than one response options
  o A comparison of resident’s status on current assessment and prior assessment.

Care Area Assessments

THE CARE AREAS
Care Area Assessment (CAA)

- Triggered care areas form a critical link between MDS and care planning decisions
- CAAs cover the majority of problem areas known to be problematic for nursing home residents
  - Other areas may need assessment as well
- Triggered CAA must be assessed → may or may not warrant being addressed by care plan

The 20 Care Areas

1. Delirium
2. Cognitive Loss
3. Visual Function
4. Communication
5. ADLs-Functional Status
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutrition Status
13. Feeding Tube(s)
14. Dehydration/Fluid Maintenance
15. Pressure Ulcer(s)
16. Psychotropic Medication Use
17. Physical Restraints
18. Pain
19. Return to Community Referral
20. Performance Status

CONDUCTING THE ASSESSMENT
Conducting the Assessment

Step 1: Identify the trigger

• Usually a sign, symptom, or other indicator of possible problem, need, or strength

  Example
  Acute onset of mental status change (C1600)

Conducting the Assessment

Step 2: Identify the triggered Care Area

  Example
  Acute onset of mental status change (C1600) triggers Delirium care area

Conducting the Assessment

Step 3: Conduct thorough assessment of the entire Care Area

• Include factors that could cause or contribute to the symptom

• Include factors for which the symptom places the resident at risk

• Some factors will be on the MDS, many will not
Conducting the Assessment
Tools Requirement

- Must be current, evidence-based or expert-endorsed research and clinical practice guidelines/resources
- The facility should be able to identify the resources they use upon request
- Requirement is consistent with F492 – services must meet professional standard of quality

Appendix C Resources

- Staff should follow their facility’s chosen protocol or policy for performing the CAA.
- Resources provided in Appendix C are not mandated.
- CMS does not endorse the use of any particular resource(s) including those in Appendix C.
- Resources selected may be used outside of RAI process also

Conducting the Assessment
Tools Option 1

- Review of Indicators for each care area provided in Appendix C
- Each provides a checklist of indicators that guides the assessment for the particular care area
- Also provides location and guidelines for documentation
Conducting the Assessment
Tools Option 2

• Appendix C also offers a list of resources that may be used for this purpose
  o May be accessed online or through professional associations or other organizations
  o Not an exhaustive list – providers are free to use others that meet regulatory requirement

Conducting the Assessment

Step 4: Draw conclusions based on the information collected

• What is causing or contributing to the problem for this resident?
• What is this resident at risk for related to the problem?
• What other health professionals should be involved?

DOCUMENTATION
CAA Documentation

• The nature of the issue or condition - what is the problem for this resident?
• Causes and contributing factors
• Complications affecting or caused by the care area for this resident
• Risk factors that arise because of the presence of the condition
• Factors that must be considered in developing individualized care plan interventions
• Need for referrals to other health professionals

CAA Documentation

• Written documentation of the CAA findings and decision-making process may appear anywhere in resident's record
• No particular location or format is required
• Section V indicates Location and Date of CAA documentation r/t decision-making

CAA Documentation

Popular Formats

• Checklist with summary analysis
  o See Jane Doe Delirium Review of Indicators
CAA Documentation
Popular Formats

- CAA review note summarizing and analyzing findings
  - See next slides

Delirium Review Note

Jane Doe

- Possible causes and contributing factors:
  - Pulse < 60 h/ Digoxin (MARs)
  - Low sodium (2/20/10 lab work), takes Lasix and K+ (MAR)
  - Blood sugar fluctuations (MARs)
  - CHF w/ pulmonary edema prior to admission, hx MI, cardiac dysrhythmias (H&P)
  - SOBOE with PT (PT notes 2/19, 2/20, 2/23, 2/25, 2/28)
  - Hypothyroidism, renal insufficiency (H&P)
  - 30 lb. unplanned weight loss in year prior to hospitalization (H&P and wife)
  - ADL decline within last 6 months (per wife and resident)
  - Remeron dose increased 2/20 (MD orders and MAR)
  - Nightmares last three nights (nurses notes)
  - Seeing murals, hearing music that wasn’t there (NN 2/25-2/27)
  - Recent move from Atlanta to Phoenix (transfer documents, SS assessment)
  - Lost hearing aids during move

Analysis of Findings: Jane Doe

- This analysis would be the same as the analysis on the last page of the Delirium Review of Indicators checklist for Jane Doe. Because format does not change content requirement
  - Description of the problem
  - Causes and contributing factors
  - Risk factors
CAA Documentation

Popular Formats

• No additional note or summary other than routine chart documentation
  - In section V assessor provides locations in the chart where information is located

  In some cases, it may be prudent to write a summary of the CAA information, especially if the assessment documentation in the record is incomplete, unclear, too scattered, or unfocused. It may also be useful to have the information summarized for quick reference by staff.

Regardless of tool or format, documentation should walk through the evidence of and conclusions about the root causes, contributing factors, risk factors, referrals to other health professionals.

RAI Manual Chapter 4

Individualized Care Through Evidence-Based Assessment and Care Planning
Objectives

• To review the care processes underlying assessment and care planning
• To consider key criteria for evidence-based care
• To help facilities identify an efficient and effective approach to evidence-care planning
• To show how evidence-based care planning can help attain individualized ("person-centered") care

Background

• Per OBRA ‘87, facilities must
  o Provide necessary care and services
  o Attain improvement when possible
  o Avoid decline unless unavoidable
  o Complete comprehensive, standardized assessment
  o Use results of assessment to develop, review, and revise each resident’s comprehensive plan of care

Uses and Cautions

• Most tools and products have accompanying information
  o Extolling virtues
  o Giving directions for use
  o Offering cautions and warnings
• Especially vital when improper or non-indicated use has potential for major complications
Uses and Limits of the RAI

- RAI is meaningful and helpful when used correctly for intended purposes.
- RAI use can be a problem; especially if:
  - Used without adequate understanding
  - Used in a manner that exceeds the user’s knowledge and understanding
  - Used for purposes for which not designed
- Skill of assessors can vary greatly, just like automobile driver or cyclists.

Key Issues

- What is the clinical standard of practice?
  - How does it differ from “common practice” or “conventional wisdom”?
- What does it mean to give evidence-based care?
  - In contrast to allegations thereof
- What is evidence-based care?
  - Requires applying BOTH
    - Evidence about the resident/patient AND
    - Evidence about assessing and managing resident/patient’s risks, conditions, and symptoms

Going Beyond the RAI

- Federal requirements for ongoing assessment responsibility
- Quality of Care regulation (42 CFR 483.25 [F 309])
  - Necessary care and services to attain or maintain highest practicable physical, mental, and psychosocial well-being
    - In accordance with comprehensive assessment and plan of care
RAI and Beyond: Professional Standards

- Services provided or arranged must meet professional standards of quality
  - 42 CFR 483.75(b)
- Elements of assessment and care that are consistent with professional standards
  - OBRA regulations and guidance (e.g., F314 42 CFR 483.25(c) Pressure Ulcers and F329 42 CFR 483.25(l)(1), Unnecessary Medications)
- Responsibility to assess and address all care that is needed by individual residents, regardless of whether covered by the RAI
  - 42 CFR 483.20(b)

Steps to Evidence-Based Care

- Collect and analyze information in order to perform
  - Accurate problem definition & cause identification resulting in
    - Effective clinical problem solving and decision making leading to
      - Appropriately individualized interventions


Steps to Evidence-Based Care

- Critical intermediate steps in between collecting information and choosing interventions
  - Accurate problem definition and cause identification
  - Effective clinical problem solving and decision making
- RAI and related guidance not designed or intended to cover intermediate steps fully
  - Only offers a general framework
The Three Human Dimensions

**PSYCHOSOCIAL**

**PHYSICAL**

**FUNCTIONAL**

Health, Illness, and Impairment

- Health can be defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” - World Health Organization (WHO)

- Health care alone is unlikely to produce “health”
  - However, it can affect well-being profoundly, for better or worse

Sound and Unsound Care

- Sound
  - Care of person with [Condition A + Condition B + Condition C + Condition D + Condition E]

- Unsound
  - [Care of Condition A] + [Care of Condition B] + [Care of Condition C] + [Care of Condition D] + [Care of Condition E]
Care in Context

- Fragmented or uncoordinated ("silo") care
  - Biologically unsound because it
    - Is not based on the "big picture"
    - Approaches issues as distinct entities
    - Fails to identify root causes
    - Fails to address causes and consequences in proper context
    - May cause new or additional complications while trying to address issues in isolation

Sound Care: History and Context

- What are the likely differences in cause, approach, and context if someone
  - Gets delirium and then gets anorexia
  - Gets anorexia and then gets delirium
  - Has a significant condition change with change in mental function and anorexia at the same time
- MDS 3 / RAI focus on "interview"
  - But only for several areas
- Key element of history taking applies across the board

Evidence-Based Care

- Evidence-based care refers to evidence about the illness, symptom, condition, or risk AND evidence about the resident
  - Requires detailed and clear findings and problem statement
  - Requires a "story"
    - Chronology of symptoms and events, not just random data / diagnoses
- Thus, a history is key to identifying causes and choosing appropriate interventions
**Comprehensive Assessment: Key Elements**

- DeGowin: Bedside Assessment (original title)
  - Since 1965, a classic reference on the key elements of history taking and examination
  - Content is universal, enduring, and relevant to anyone of any discipline who assesses a human being

**History Taking: Key Objectives**

- Taking a . . . history has four objectives:
  - 1) Discovering symptoms (issues, concerns, wishes, goals, preferences)
  - 2) Obtaining accurate quantitative descriptions
  - 3) Securing a precise chronology of events
  - 4) Determining how the illness (impairment, psychosocial concern) has changed the resident/patient’s life

**Implications**

- Detailed chronological history and basic physical assessment are essential
  - Especially, in those with complex acute or chronic disease or multiple causes and consequences
  - Otherwise, little more than guesswork
- History and exam help with thinking about situation and its causes
  - Testing and consultation often less helpful
**Problem Definition**

- Evidence-based care requires a clear and detailed statement of the issue
- Difference between a “chief complaint” and a problem statement
- An issue or problem is different from a finding
  - e.g., a single piece of information from the MDS or a test result

**Defining the Issue**

- Other examples of a “chief complaint”
  - Resident has a headache
  - Resident is vomiting
  - Resident cannot be aroused
  - Resident is “agitated”
  - Resident coughs when she eats
  - Resident is not participating as usual
- All of these need much more detail to be meaningful

**Implications**

- MDS data often at level of a chief complaint or isolated finding
  - Missing important detail / lacks a chronological story
- Common practice: treat/care plan chief complaint
  - May result in inadequate or problematic care
- Important to avoid premature interpretation
  - Such as failing to record seemingly irrelevant symptoms or events
  - May be problematic to assume the conclusion and thereby fail to seek additional information
  - (e.g., behavior due to UTI, depression, or comfort needs)
Seeing, Hearing, and Believing

- Common widespread advice
  - “Believe whatever the resident tells you.”
  - “Accept whatever the resident tells you about pain”
- However, that can easily be misunderstood or misrepresented
  - It does not mean
    - Don’t question; don’t challenge
    - Just take whatever you are told and act on it

Reasonable Expectation?

- Describing and presenting detailed history is not diagnosing
  - A health care background is not required to provide symptom details
- Presenting inadequate information or conclusions / interpretations based on inadequate information often problematic
  - May result in irrelevant / harmful interventions

Essential Basis For Care Planning

- Evidence-based care enhanced when staff focus on
  - Carefully gathering, documenting, and reporting chronological history (“tell a story”)
  - Obtaining as much detail as possible from the resident
    - Or, alternatively, constructing and reporting a good, detailed “story” as the surrogate historian
  - Reporting and documenting objective details of observations and examinations
Care Plan Together or Separately?

- Evidence-based approach
  - Define problem / issue / concern clearly
  - Figure out what is linked to what
  - Develop sound hypotheses
    - Based on careful problem definition and cause identification
  - To extent possible, care plan related issues together

Care Plan Separately or Together?

- Separate care plan often not required for each finding
  - BECAUSE a single trigger can have multiple causes and contributing factors AND multiple items can have a common cause or related risk factors
- THEREFORE, often appropriate to combine care plans or cross-reference related interventions

Summary: IDT Responsibility

- Facility’s IDT, including physicians, must identify causes and connect causes and consequences
  - BECAUSE it is essential to resident-centered care and the MDS and CAAs not designed to do so
- Qualified, interested, and capable practitioners are needed
  - Identify multiple causes of a single problem or multiple problems or complications related to one or more underlying causes
  - Identify appropriate generic and cause-specific interventions
The comprehensive care plan:
- Is an interdisciplinary communication tool
- Must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being
- Must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident’s written plan of care.

42 CFR 483.25

Care planning requires one to look at the entire picture of the resident. Human beings are complex, and issues should not be looked at in isolation. When considering care planning and goals, a resident’s preferences for the care they desire to receive should be honored – whether or not you believe that his or her choices are “good” or “bad.” Do we make mistakes in care planning and intervention choices? Can we do everything correctly and still get not so great outcomes? Is there a way that we can mitigate these types of issues in the care planning process?

Ultimately, the creation of a sound care plan requires good assessment and clinical problem solving and decision-making. A well-developed and executed assessment and care plan:
1. Looks at the entire picture of the resident – History, physical assessment and observations
2. Identifies and incorporates the resident’s unique characteristics, abilities, strengths, and needs
3. Identifies possible issues/conditions and causes, contributing factors
4. Uses data collected to identify resident specific interventions that address a resident’s goals – and those goals align with resident preferences for care

S.M.A.R.T. Goals

4. Provides a common understanding of the resident to all disciplines

5. Identifies a process for monitoring and evaluating response to care

The RAI and Care Planning

Monitoring

Monitoring entails the establishment of:
- Monitoring criteria (e.g. goal, timeline, lab testing)
- Process for documenting response to interventions

It requires the ability of clinicians to not only identify response to interventions, but effectiveness as well as adverse consequences of specific interventions

Monitoring allows for the interdisciplinary team to determine the resident’s progress towards his or her goal(s) and if changes are needed to the plan of care

Evaluation

Evaluation is a determination made of the extent to which current and proposed treatments and services have achieved their expected outcomes.

It is an ongoing process that involves:
- Analyzing the success/failure of interventions
- Determining if a modification to the care plan is required
- Input from the IDT and resident, family, other practitioners/specialists (as applicable)
Questions to ask:

- Have the cause-specific interventions chosen to address a particular resident’s physical, functional, psychosocial needs, problems, concerns, risks and goals been met?
- If yes, discontinue intervention – maintenance
- If no – why not? What needs to change? Examples:
  - Timing of the intervention – priority change
  - Was the original goal over-ambitious? Not ambitious enough?
  - Is the intervention (or aspects of the intervention) causing unexpected results?

Final Thoughts

- To promote resident’s highest practicable level of functioning, improvement where possible and maintenance/prevention of avoidable decline.
- Remember we are dealing with human beings – not the pressure ulcer in Room 210, or the dressing change in Room 550.
- Care planning is an essential piece of the care delivery process.