The Care Area Assessments (CAAs): Completing Them to Drive Effective Assessment and Care Planning

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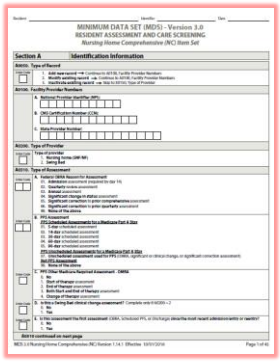

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

Section A Identification Information

Session Objectives

Upon completion of the program, the participant will:

- Describe the three components of the Resident Assessment Instrument (RAI)
- Discuss the purpose of the Care Area Assessment (CAA) process
- Identify the 20 care areas
- Articulate key functions included in each step of care planning
- Describe the elements of an acceptable care plan goal

RAI User's Manual

- The information in this program refers to publicly available information as of the date of the presentation.
- For the most accurate and up-to-date information regarding the RAI, including the Minimum Data Set, Version 3.0 (MDS 3.0), please refer to the CMS *RAI User's Manual* Web page at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

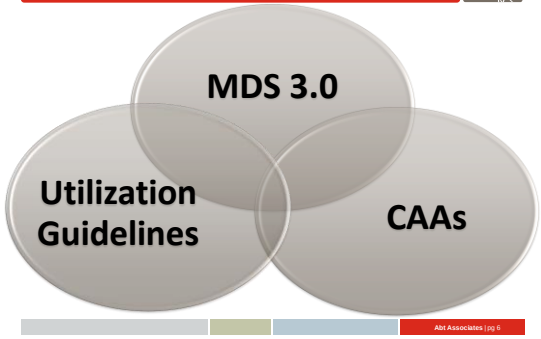
Background: Regulatory Requirements and an Overview of the RAI

Regulatory Requirements

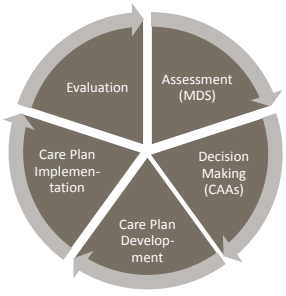
- Facilities must complete a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity and needs.
- The results of the assessment are to be used to develop, review, and revise each resident's comprehensive plan of care.
- 42 CFR §483.20 Resident Assessment
- Appendix PP:

  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

The RAI



The RAI in Action



The MDS: A Starting Point

- It is a collection of basic physical, functional, and psychosocial information about residents.
- The MDS provides a foundation for a more thorough assessment and the development of an individualized care plan.
- The MDS identifies actual or potential areas of concern.

The CAA Process

The CAA Process

- The CAA process provides a framework for clarification of a resident's functional status and related causes of impairments.
- It provides a basis for additional assessment.
- The assessment of the causes and contributing factors gives additional information to help develop a comprehensive plan of care.

The CAA Process

Helps the interdisciplinary team (IDT) to:

- Consider each resident as a whole,
- Identify areas of concern,
- Develop interventions in the context of the resident's condition, choices, and preferences for interventions, and
- Address the need and desire for other important considerations (e.g., palliative care).

The CAA Process

- The CAA Process does not mandate any specific tool for completing the further assessment of the triggered areas.
- Facilities are instructed to identify and use tools that are current and grounded in current clinical standards of practice.
- Appendix C of the RAI User's Manual contains resources.

The CAA Process

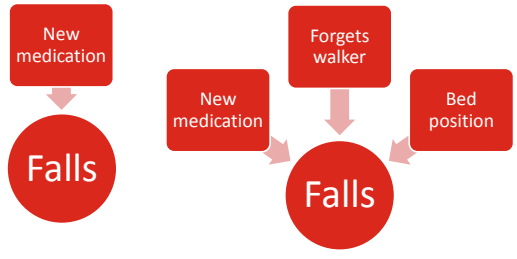
- The CAA process involves identifying and clarifying areas of concern triggered by MDS coding.
- Care Area Triggers (CATs) identify conditions that may require further evaluation.
- Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making.
- Further assessment of a triggered care area may identify causes, risk factors, and complications associated with the care area condition.

Your Turn: The CAA Process

With which of the following assessments types is the CAA process required?

A. Quarterly assessment
B. Significant correction of a prior quarterly assessment
C. Significant change in status assessment
D. 14-day PPS assessment

Risk Factors – One or Many



Not All CAAs Identify Problems

- Some triggers indicate areas of resident strengths, and can suggest possible approaches to improve a resident's functioning or minimize decline.
- An example: G0900A, Resident believes he or she is capable of increased independence in at least some ADLs.

The CAA Process May Help the IDT:

- Identify and address associated causes and effects;
- Determine whether and how multiple triggered conditions are related;
- Identify a need to obtain additional medical, functional, psychosocial, financial, or other information about a resident's condition;
- Identify whether and how a triggered condition actually affects the resident;

The CAA Process May Help the IDT (continued):

- Review the resident's situation with a health care practitioner to try to identify links among causes and between causes and consequences;
- Determine whether a resident could potentially benefit from rehabilitative interventions; and
- Develop an individualized care plan.

Your Turn: The CAA Process

True or False:

If a CAA triggers, the IDT must develop a care plan for the care area.

A. True

B. False

Relevant Documentation for Each Triggered CAA Describes:

- Causes and contributing factors;
- The nature of the issue or condition;
- Complications affecting or caused by the care area for this resident;
- Risk factors related to the presence of the condition;
- Factors that must be considered in developing individualized care plan interventions;
- The need for additional evaluation by the attending physician and other health professionals, as appropriate; and
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA.

CAA Documentation

- Documentation may appear anywhere in the resident's record.
- Surveyors may ask facility staff to provide evidence that the CAA process has been completed.
- Use the "Location and Date of CAA Documentation" column on the CAA Summary to note where the CAA information and decision-making documentation can be found in the resident's record.

Your Turn: CAA Documentation

True or False:

Noting "see care plan" in the "Location and Date of CAA Documentation" area for each triggered CAA in Section V of the MDS always ensures that the CAA documentation requirements have been met.

A. True

B. False

When Is the RAI Not Enough?

- The RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.
- The MDS may not trigger every relevant issue.
- Not all triggers are clinically significant.
- The MDS is not a diagnostic tool or treatment selection guide.
- The MDS does not identify causation or history of problems.

The RAI and Care Planning

The Comprehensive Care Plan

- An interdisciplinary communication tool
- Must include measurable objectives and time frames and must describe the services that are to be furnished
- Must be reviewed and revised periodically
- Is informed by the results of the RAI

Recognition and Assessment

- Identify and collect information that enables proper definition of their conditions, strengths, needs, risks, problems, and prognosis
- Obtain a personal and medical history
- Perform a physical assessment

Problem Definition

- Identify consequences and complications
- Clearly state the individual's strengths, problems, needs, deficits, and concerns
- Define significant risk factors

Diagnosis and Cause-and-Effect Analysis

- Identify causes of and factors contributing to the individual's current issues
- Identify pertinent evaluations and diagnostic tests
- Identify how findings relate to one another
- Identify how addressing causes is likely to affect consequences

Identifying Goals and Objectives of Care

- Clarify prognosis
- Define overall goals for the individual
- Identify criteria for meeting goals

Selecting Interventions and Planning Care

- Identify specific symptomatic and cause-specific interventions
- Identify how current and proposed treatments and services are expected to help attain overall goals for the individual
- Define anticipated benefits and risks of various interventions
- Clarify how specific treatments and services will be evaluated

Monitoring of Progress

- Identify the individual's response
- Identify factors that are affecting progress
- Define or refine the prognosis
- Define or refine when to stop or modify interventions
- Review effectiveness and adverse consequences
- Adjust interventions as needed
- Identify when care objectives have been achieved

A Well-Developed Care Plan

- Looks at each resident as a whole human being
- Gives the IDT a common understanding of the resident
- Provides additional clarity of potential issues and/or conditions
- Reflects the resident/resident representative input and goals for health care
- Provides information regarding how the causes and risks associated with issues and/or conditions can be addressed
- Re-evaluates the resident's status at prescribed intervals

The Care Plan Should Be Oriented Towards:

- Preventing avoidable declines
- Managing risk factors
- Preserving and building upon resident strengths
- Applying current standards of practice
- Evaluating treatment
- Respecting the resident's right to decline treatment
- Offering alternative treatments
- Using an appropriate interdisciplinary approach to care plan development
- Involving resident, resident's family and other resident representatives
- Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs
- Involving the direct care staff
- Addressing additional care planning areas

Care Plan Goals

Subject	Verb	Modifiers	Time Frame	Goal
Mr. Jones	will walk	50' daily with the help of one nursing assistant	for the next 30 days	in order to maintain ability to walk to the dining room for all meals

Your Turn: Care Planning

Each triggered CAA must have it's own care plan.

A. True

B. False

The Twenty Care Areas

The Twenty Care Areas

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. Activity of Daily Living (ADL) Functional / Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration/Fluid Maintenance
15. Dental Care
16. Pressure Ulcer
17. Psychotropic Medication Use
18. Physical Restraints
19. Pain
20. Return to Community Referral

Delirium

- Symptoms of delirium are indicated by the presence of an acute mental status change and/or the presence of inattention, disorganized thinking or altered mental status on the current non-admission comprehensive assessment

Let's Chat

- The focus of the care plan for a resident who triggers for delirium should be to address the underlying clinical issues/conditions identified through this assessment process that have led to the actual or potential delirium.
- If you are the clinician completing the Delirium CAA review for a resident with suspected delirium, who might you ask to help you with the assessment?
- Use the chat to type in the discipline of the individual that you will ask for help and what you will request their help with.
- Example: *Physician – rule out infection*

Cognitive Loss/Dementia

- BIMS summary score is less than 13
- Short-term memory problem
- Long-term memory problem
- At least some difficulty making decisions regarding tasks of daily life
- Presence of inattention, disorganized thinking, or altered level of consciousness
- Presence of any behavioral symptom (verbal, physical or other)
- Rejection of care occurred at least 1 day in the past 7 days
- Wandering occurred at least 1 day in the past 7 days

Visual Function

- Cataracts, glaucoma, or macular degeneration
- Any vision problems are present

Communication

- Hearing problems are present
- Impaired ability to make self understood through verbal and non-verbal expression of ideas/wants
- Impaired ability to understand others through verbal content

ADL Functional/Rehabilitation Potential

- The resident has at least some cognitive skills for daily decision making or their BIMS summary score is 5 or greater and assistance with any ADL, including bathing, is needed
- The resident has at least some cognitive skills for daily decision making or their BIMS summary score is 5 or greater and the resident or staff believe that the resident is capable of increased independence

Your Turn: ADL Functional/Rehabilitation Potential

Because the Functional/Rehabilitation Potential CAA will not trigger for a resident with significant cognitive impairment as evidenced by a BIMS score of 4, a care plan with a rehabilitation focus is not indicated for such a resident.

A. True

B. False

Urinary Incontinence and Indwelling Catheter

- ADL assistance for toileting is needed
- Indwelling catheter use
- External catheter use
- Intermittent catheterization
- Urinary incontinence
- Moisture associated skin damage

Psychosocial Well-Being

- Resident mood interview or staff assessment indicates the presence of little interest or pleasure in doing things
- It is not very important or not at all important to the resident that he or she participates in favorite activities
- Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities
- Physical or verbal behavioral symptoms directed toward others are present and the resident does not have dementia nor Alzheimer's disease
- The resident indicates any six items on the interview for activity preferences is not at all important

Mood State

- The resident has had thoughts he/she would be better off dead or thoughts of hurting him/herself
- The staff assessment of resident mood suggests the resident states life isn't worth living, wishes for death, or attempts to harm self
- The resident mood interview total severity score (TSS) on the current assessment is greater than the prior assessment
- The staff assessment of resident mood TSS on the current assessment is greater than the prior assessment
- The resident mood interview TSS is 10 or greater
- The staff assessment of resident mood TSS is 10 or greater

Behavioral Symptoms

- Rejection of care
- Wandering
- Change in behavior indicates behavior, care rejection or wandering has gotten worse since prior assessment
- Presence of physical or verbal behavior directed at others or other behavior symptoms not directed toward others

Activities

- Resident has little interest or pleasure in doing things as indicated by the resident interview of staff assessment of mood
- Any six of the items listed in the Interview for Activities Preferences are indicated as not important at all, important but can't do, or no choice
- Any six items on the staff assessment of activity preference are not checked

Falls

- Wandering occurs
- Balance problems during a transition are present
- Fall history at admission indicates resident fell anytime in the last month prior to admission or anytime in the last 2 to 6 months prior to admission
- Resident has fallen at least one time since admission or the prior assessment
- Resident received antianxiety or antidepressant medication on one or more days
- Trunk restraint used in bed or in the chair or out of bed

Nutritional Status

- Dehydration
- Body mass index (BMI) is too low or too high
- Weight loss
- Weight gain
- Parenteral/IV feeding
- Mechanically altered diet
- Therapeutic diet
- Pressure ulcers (Stage 2-4 or unstageable)

Feeding Tubes

- Feeding tube in use while a resident or while not a resident

Dehydration/Fluid Maintenance

- Fever
- Vomiting
- Dehydration
- Internal bleeding
- Infection
- Constipation
- Parenteral/IV feeding (while a resident or while not a resident)
- Feeding tube (while a resident or while not a resident)

Dental Care

- Broken or loosely fitting full or partial denture
- No natural teeth or tooth fragment(s) (edentulous)
- Abnormal mouth tissue
- Obvious or likely cavity or broken natural teeth
- Inflamed or bleeding gums or loose natural teeth
- Mouth or facial pain, discomfort or difficulty with chewing

Pressure Ulcer

- The resident required ADL assistance for bed mobility or the activity did not occur or occurred once or twice
- Frequent urinary incontinence
- Frequent bowel continence
- Weight loss in the absence of physician-prescribed regimen
- At risk for developing pressure ulcers
- One or more pressure ulcer(s)
- One or more pressure ulcer(s) that has gotten worse since prior assessment
- Trunk restraint used in bed
- Trunk restraint used in chair or out of bed

Psychotropic Medication Use

- Antipsychotic medication
- Antianxiety medication
- Antidepressant medication
- Hypnotic medication

Physical Restraints

- Bed rail restraint used in bed
- Trunk restraint used in bed
- Limb restraint used in bed
- Other restraint used in bed
- Trunk restraint used in chair or out of bed
- Limb restraint used in chair or out of bed
- Chair restraint that prevents rising used in chair or out of bed
- Other restraint used in chair or out of bed

Pain

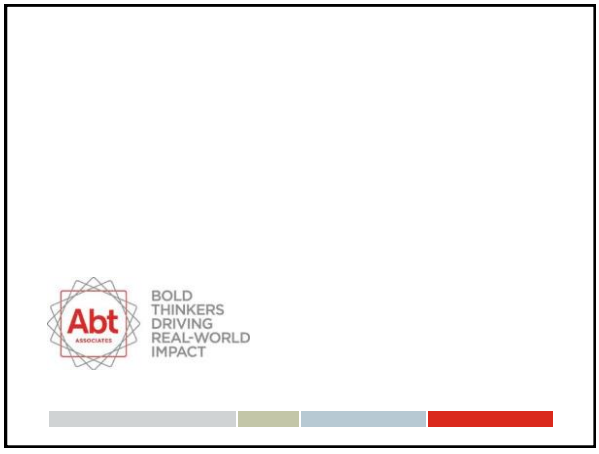
- Pain has made it hard for resident to sleep at night
- Resident has limited day-to-day activity because of pain
- Pain numeric intensity rating has a value from 7 to 10
- Verbal descriptor of pain is severe or very severe
- Pain is frequent and numeric pain intensity rating has a value of 4 through 10 or verbal descriptor of pain is moderate or greater
- Staff assessment reports resident indicates pain or possible pain is present at any frequency

Return to Community Referral

- Referral is or may be needed but has not been made to local contact agency

Questions and Answers

- And a final reminder….
- Use the Manual often. It's available on the CMS ***RAI User's Manual*** web page at the following link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html


Abt
ASSOCIATES
BOLD
THINKERS
DRIVING
REAL-WORLD
IMPACT