



Minimum Data Set (MDS) 3.0
Instructor Guide

Section V Care Area Assessment (CAA) Summary

Objectives

- State the purpose of Section V Care Area Assessment (CAA) Summary.
- List prior assessment data required for Section V.
- Describe how to document Care Area Assessments for Section V.
- Code Section V correctly and accurately.
- State the purpose of Chapter 4 of the RAI Manual.

Methodology

This lesson consists of a lecture.

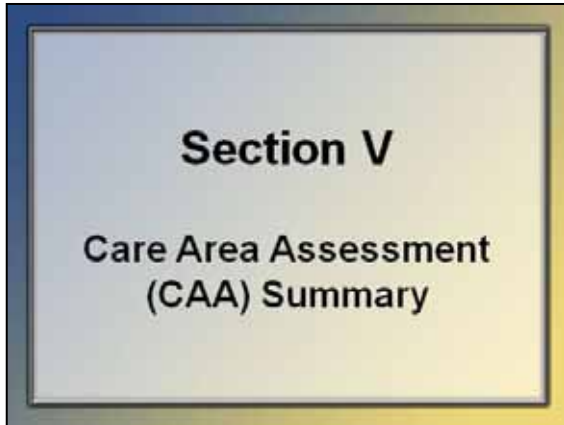
Training Resources

- Instructor Guide
- Slides 1 to 39

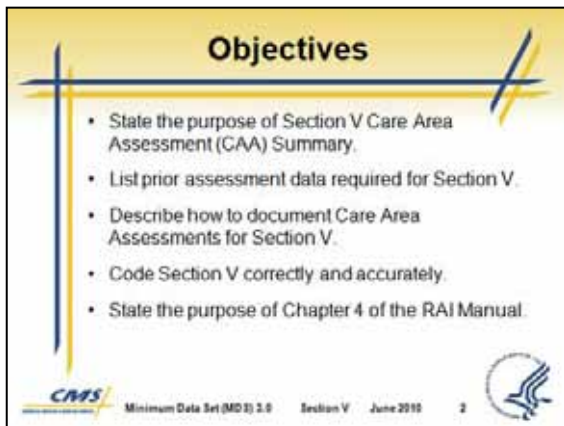
Instructor Preparation

- Review the Instructor Guide.
- Review learning objectives for the lesson.
- Rehearse with slide presentation.

SLIDES	INSTRUCTIONAL GUIDANCE
<div data-bbox="217 331 256 525" style="writing-mode: vertical-rl; transform: rotate(180deg);">Notes</div> <div data-bbox="264 331 1370 525"> <div data-bbox="264 331 1370 373" style="background-color: #cccccc; text-align: center;">Instructor Notes</div> <div data-bbox="264 373 1370 489"> <p>Direct participants to turn to Section V in the MDS 3.0 instrument.</p> </div> <div data-bbox="264 489 1370 525" style="background-color: #cccccc; text-align: center;">Instructor Notes</div> </div> <div data-bbox="1370 331 1399 525" style="writing-mode: vertical-rl; transform: rotate(180deg);">Notes</div>	



Slide 1



Slide 2

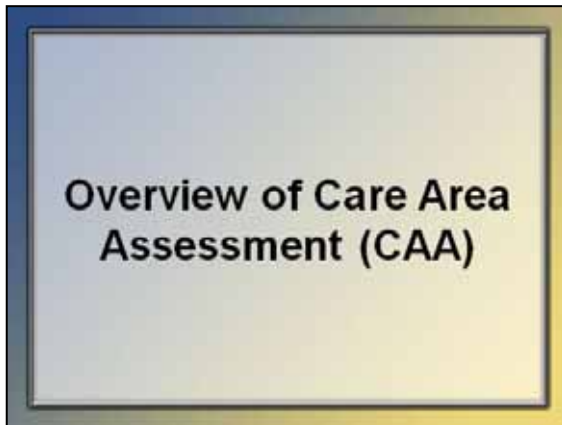
I. Introduction/ Objectives

- A. The MDS does not constitute a comprehensive assessment.
- B. It is a preliminary assessment to identify potential resident problems, strengths, and preferences.
- C. This section assembles scores and provides Care Area Assessment Summaries to provide a holding place for these preliminary results.

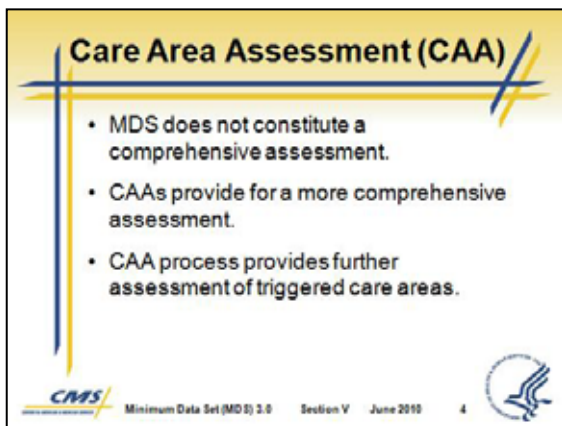
D. Objectives

- State the purpose of Section V Care Area Assessment (CAA) Summary.
- List prior assessment data required for Section V.
- Describe how to document Care Area Assessments for Section V.
- Code Section V correctly and accurately.
- State the purpose of Chapter 4 of the RAI Manual.

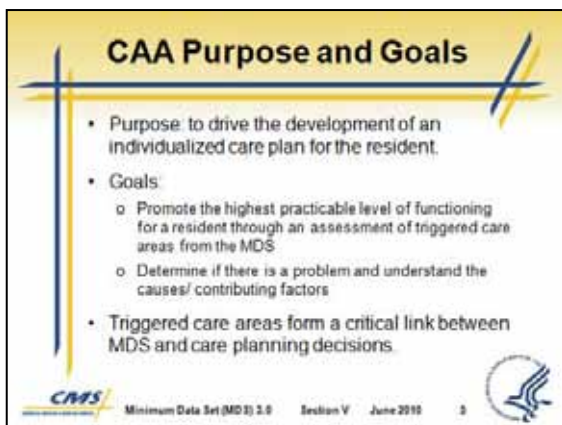
SLIDES



Slide 3



Slide 4



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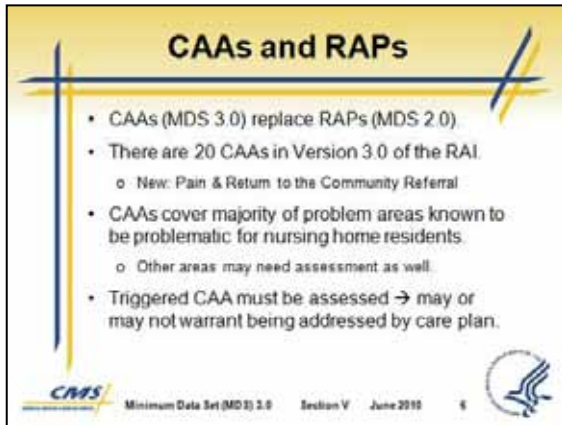
INSTRUCTIONAL GUIDANCE

II. Overview of Care Area Assessment (CAA)

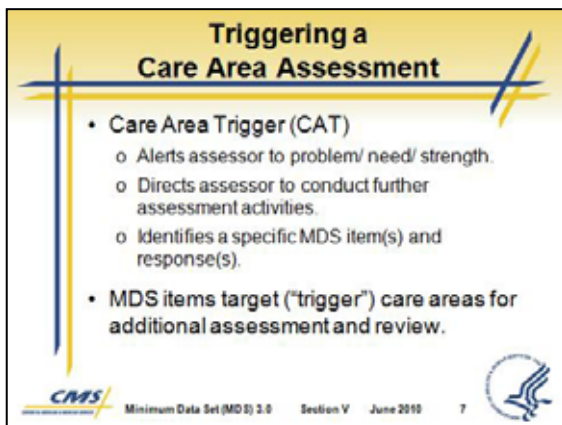
- A. The CAA process provides:
1. Starting point for guiding the review and clarification of a resident's functional status and related causes of impairments.
 2. Basis for additional assessment of potential issues, including related risk factors.
 3. Interdisciplinary team (IDT) a baseline of clinical information to help them develop a comprehensive plan of care.
- B. Care Area Assessment (CAA)
1. MDS does not constitute a comprehensive assessment.
 2. CAAs provide for a more comprehensive assessment.
 3. CAA process further assesses triggered care areas and guides staff to look for causal or confounding factors, some of which may be reversible.
- C. CAA Purpose and Goals
1. Purpose: to drive the development of an individualized care plan.
 2. Goals:
 3. Promote the highest practicable level of functioning for a resident through an assessment of triggered care areas from the MDS.
 4. Determine if there is a problem and understand the causes / contributing factors.

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5. Assessed triggered care areas form a critical link between MDS and care planning decisions.

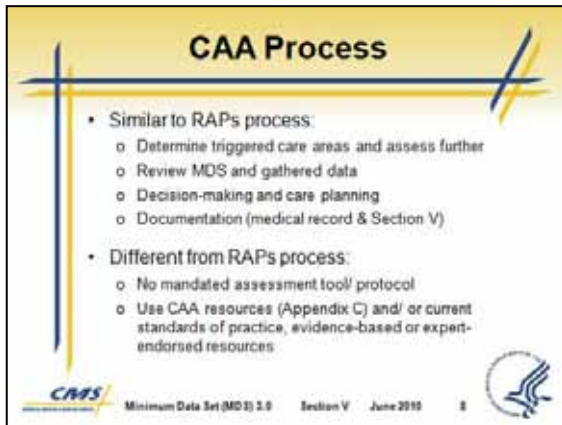
D. CAAs and RAPs

1. CAAs (MDS 3.0) replace RAPs (MDS 2.0).
2. There are 20 CAAs in Version 3.0 of the RAI.
3. New: Pain & Return to the Community Referral
4. CAAs cover the majority of problem areas known to be problematic for nursing home residents.
5. Other areas may need assessment as well.
6. Triggered CAA must be assessed as they may or may not warrant being addressed by care plan.

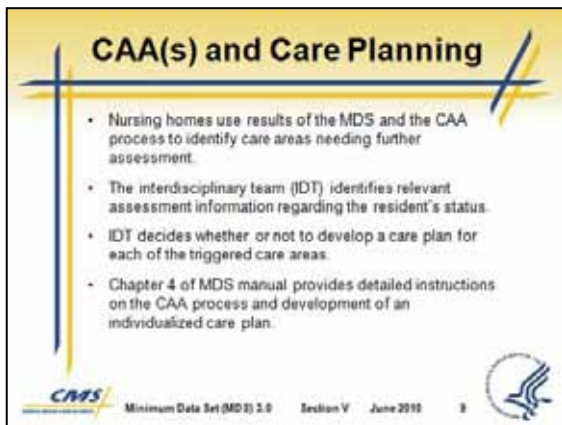
E. Triggering a Care Area Assessment

1. Care Area Trigger (CAT):
2. Alerts assessor to problem/ need/ strength.
3. Directs assessor to conduct further assessment activities.
4. Identifies a specific MDS item(s) and response(s).
5. MDS items target (“trigger”) care areas for additional assessment and review.

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F. CAA Process

1. Similar to RAPs process:
2. Determine triggered care areas and further assess.
3. Review MDS and gathered data.
4. Decision-making and care planning
5. Documentation (medical record & Section V)
6. Different from RAPs process:
7. No mandated protocol
8. Use CAA resources (Appendix C) and/ or current standards of practice, evidence-based or expert-endorsed resources.

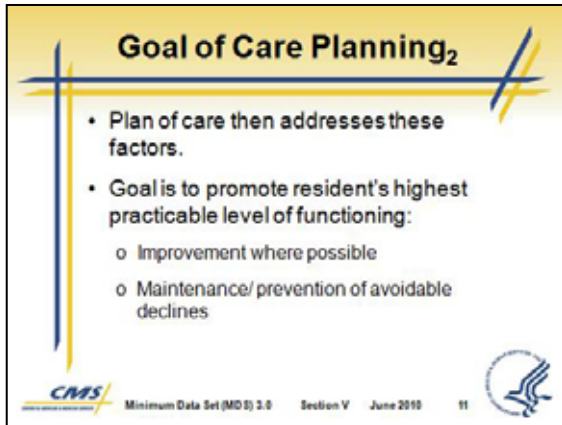
G. CAAs and Care Planning

1. Nursing homes use results of the MDS and the CAA process to identify care areas needing further assessment.
2. The interdisciplinary team (IDT) identifies relevant assessment information regarding the resident's status.
3. IDT decides whether or not to develop a care plan for each of the triggered care areas.
4. Chapter 4 of MDS manual provides detailed instructions on the CAA process and the development of an individualized care plan.

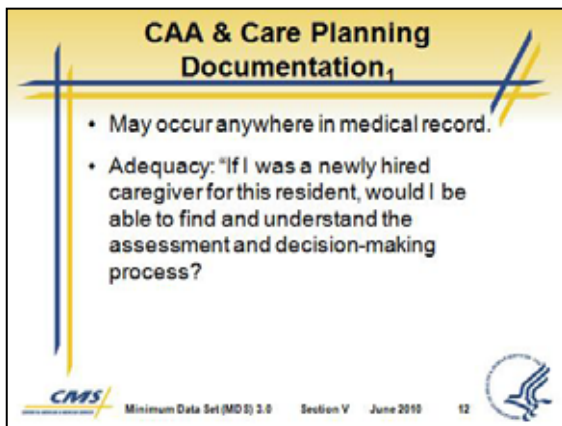
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H. Goal of Care Planning

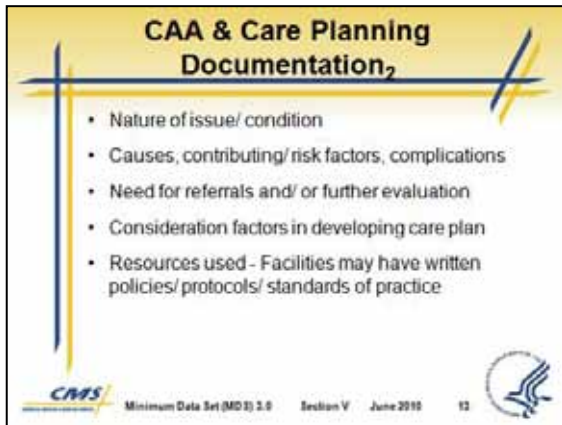
1. MDS identifies actual or potential issues.
2. CAA process provides for further assessment of triggered areas.
3. Important that CAA documentation include causal/ confounding risk factors for decline/ improvement.

4. Plan of care then addresses these factors.
5. Goal is to promote resident's highest practicable level of functioning:
6. Improvement where possible
7. Maintenance/ prevention of avoidable declines

I. CAA and Care Planning Documentation

1. May occur anywhere in medical record
2. Adequacy: "If I was a newly hired caregiver for this resident, would I be able to find and understand the assessment and decision-making process?"

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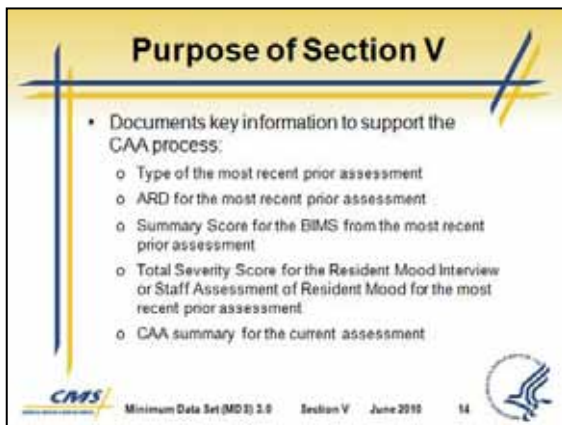
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- J. Relevant documentation for each triggered CAA describes:
1. The nature of issue or condition
 - a. What is the problem?
 - b. Why is it a problem?
 2. Causes and contributing/ risk factors, complications.
 3. Need for further evaluation by attending physician and other health professionals as appropriate
 4. Factors that must be considered in developing individualized resident-centered care plan interventions, including to care plan or not to care plan
 5. The resource(s), or assessment tool(s) used for decisions and conclusions that arose from performing the CAA.
 - a. Facilities may have written policies/ protocols/ standards of practice

K. Purpose of Section V

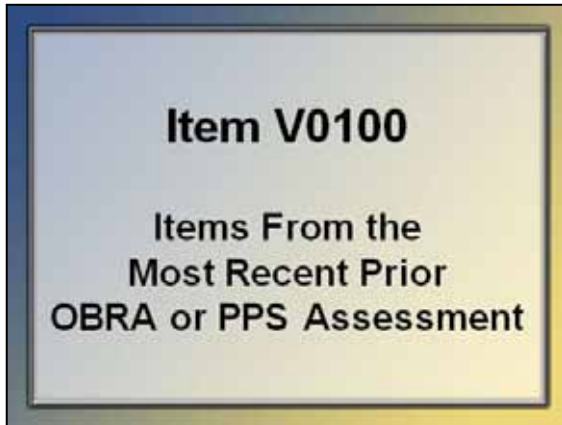
1. Section V documents key information to support the CAA process:
 - a. Type of the most recent prior assessment
 - b. Assessment Reference Date for the most recent prior assessment
 - c. Summary Score for the BIMS from the most recent prior assessment



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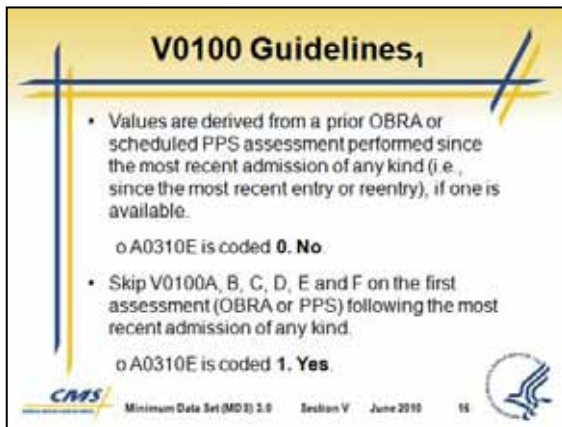
- d. Total Severity Score for the Resident Mood Interview or Staff Assessment of Resident Mood for the most recent prior assessment
- e. CAAs summary for the current assessment



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III. Item V0100 Items from the Most Recent Prior OBRA or PPS Assessment

- A. The items in V0100 are used to determine whether to trigger several of the CAAs that compare a resident's current status with their prior status.

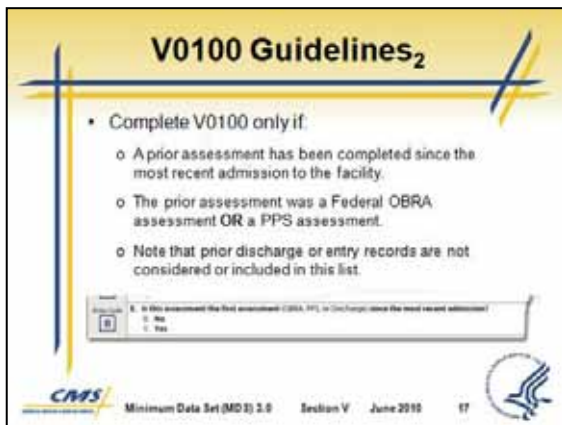


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B. V0100 Guidelines

1. The values of items V0100 A, B, C, D, E, and F are derived from a prior OBRA or scheduled PPS assessment that was performed since the most recent admission of any kind (i.e., since the most recent entry or reentry), if one is available.
 - a. A0310E is coded **0. No.**
2. Items V0100A, B, C, D, E and F are skipped on the first assessment (OBRA or PPS) following the most recent admission of any kind.
 - a. A0310E is coded **1. Yes.**

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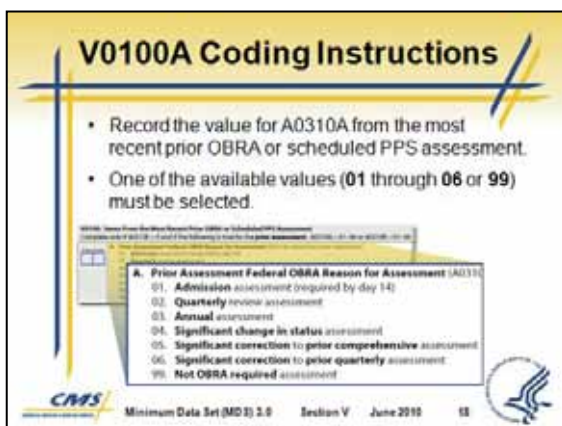
3. So complete V0100 only if:
 - a. A prior assessment has been completed since the most recent admission of any kind to the facility.
 - b. A0310E = **0. No**
 - c. Refer to example in graphic. If this is coded as **1**, do not complete item V0100.

AND

- d. The prior assessment was a Federal OBRA assessment **OR** a PPS assessment.
- e. A0310A = **01** through **06**
- f. **OR**
- g. A0310B = **01** through **06**
- h. If such an assessment is available, the values of V0100A, B, C, D, E, and F should be copied from the corresponding items on that prior assessment
- i. Note that prior discharge or entry records are not considered or included in this list.

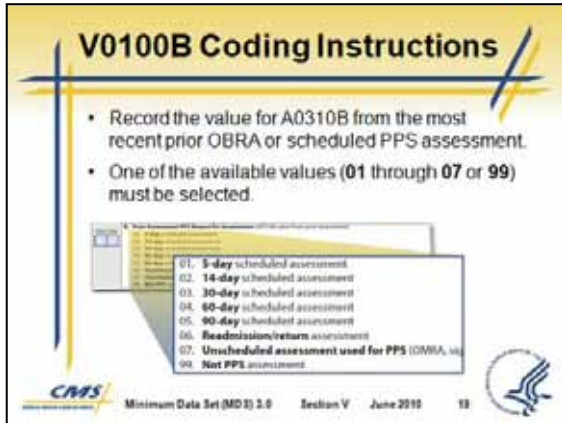
C. V0100A Coding Instructions

1. Record the value for A0310A from the most recent prior OBRA or scheduled PPS assessment.
 - a. If there is no prior assessment, code this item as **99**.
2. One of the available values (**01** through **06** or **99**) must be selected.
3. Do not leave this field blank.

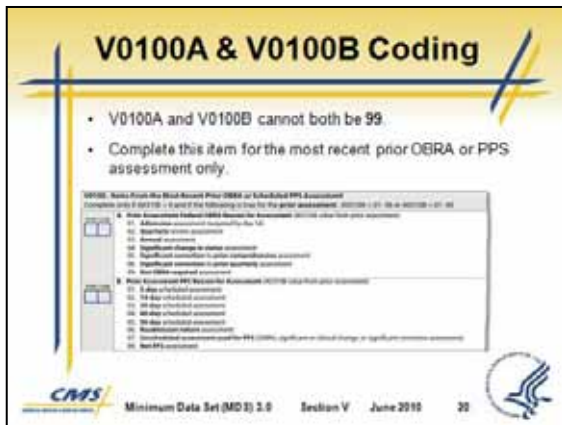


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D. V0100B Coding Instructions

1. Record the value for A0310B PPS Assessment from the most recent prior OBRA or scheduled PPS assessment.
2. One of the available values (**01** through **07** or **99**) must be selected.
3. Do not leave field blank.

E. V0100A and V0100B Coding

1. The values for V0100A and V0100B cannot both be **99**, indicating that the prior assessment is neither an OBRA nor a PPS assessment.
2. If the value of V0100A is **99** (not an OBRA assessment), then the value for V0100B must be **01** through **07**, indicating a PPS assessment.
3. If the value of V0100B is **99** (not a PPS assessment), then the value for V0100A must be **01** through **06**, indicating an OBRA assessment.
4. Complete this item for the most recent prior OBRA or PPS assessment only.

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F. V0100C Coding Instructions

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

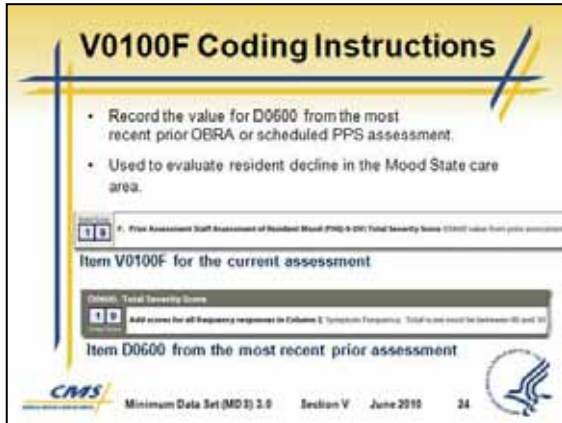
G. V0100D Coding Instructions

1. Record the value for C0500 Summary Score (for the BIMS) from the most recent prior OBRA or scheduled PPS assessment.
2. This item will be compared with the corresponding item on the current assessment to evaluate resident improvement or decline in the Delirium care area.

H. V0100E Coding Instructions

1. Record the value of D0300 (Resident Mood Interview [PHQ-9[®]] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment.
2. Complete this item if a resident interview for Section D Mood was conducted on the most recent prior assessment.
3. This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

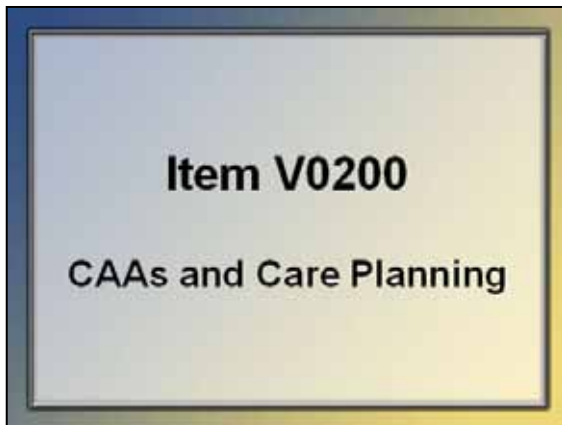
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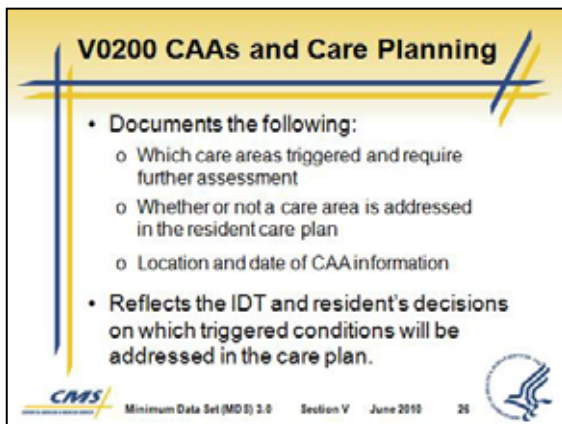
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- I. V0100F Coding Instructions
 1. Record the value for item D0600 (Staff Assessment of Resident Mood Interview [PHQ-9-OV©] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment.
 2. Complete this item if a staff assessment for Section D Mood was conducted on the most recent prior assessment.
 3. This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.



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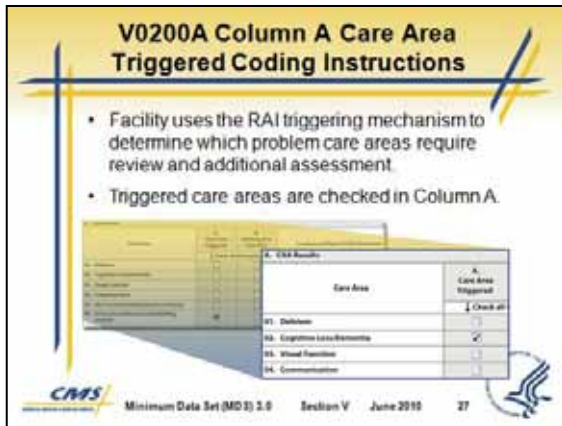
IV. Item V0200 CAAs and Care Planning



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- A. V0200 CAAs and Care Planning
 1. Items V0200A 01 through 20 document:
 - a. Which care areas have triggered & require further assessment
 - b. Whether or not a care area is addressed in the resident care plan
 - c. Location and date of CAA documentation

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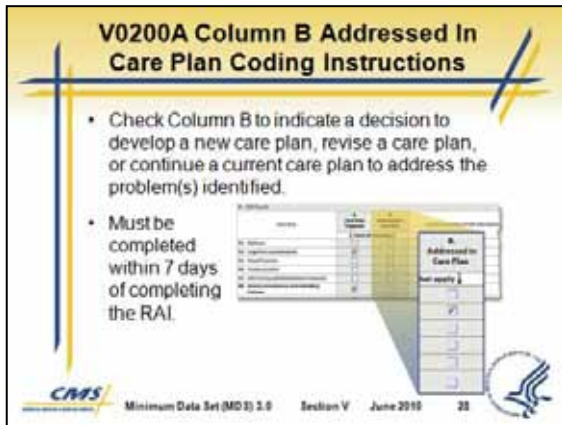


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2. The CAA Summary reflects the IDT and resident's (including resident's family or representative) decisions on which triggered conditions will be addressed in the care plan.
- B. V0200A Column A Care Area Triggered Coding Instructions
1. Facility staff uses the RAI triggering mechanism to determine which care areas require review and additional assessment.
 2. The triggered care areas are to be checked in Column A Care Area Triggered in the CAA section.
 3. For each triggered care area, use the CAA process and current standards of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area.
 4. Document relevant assessment information regarding the resident's status.
 5. Chapter 4 of the RAI manual provides detailed instructions on the CAA process, care planning, and documentation.

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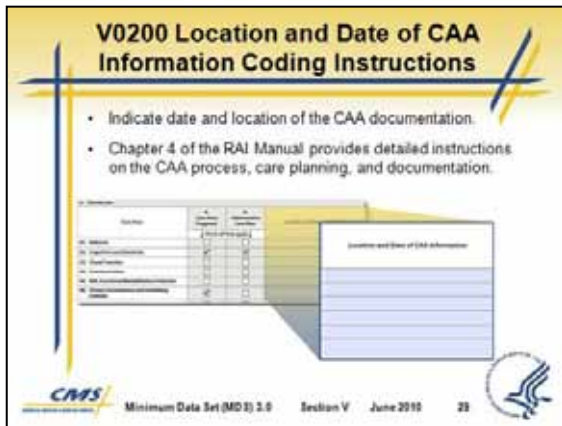
INSTRUCTIONAL GUIDANCE

C. V0200A Column B Addressed in Care Plan Coding Instructions

- For each triggered care area, check Column B Care Planning Decision - Addressed in Care Plan.
- Indicates that a new care plan, care plan revision, or continuation of current care plan is necessary to address the issue(s) identified in the assessment of that care area.
- The Care Planning Decision - Addressed in Care Plan column must be completed within 7 days of completing the RAI.
- As indicated by the date in V0200C2
- Date that the care planning decisions were completed, and that the resident's care plan was completed.

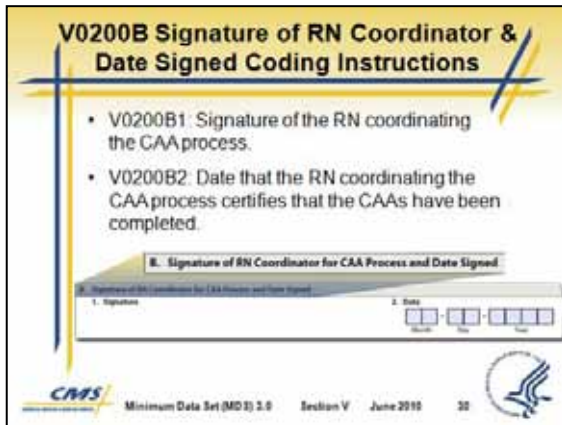
D. V0200A Location and Date Coding Instructions

- For each triggered care area, indicate the date and location of the CAA documentation in the "Location and Date of CAA Documentation" column.
- Chapter 4 of the RAI Manual provides detailed instructions on the CAA process, care planning, and documentation.

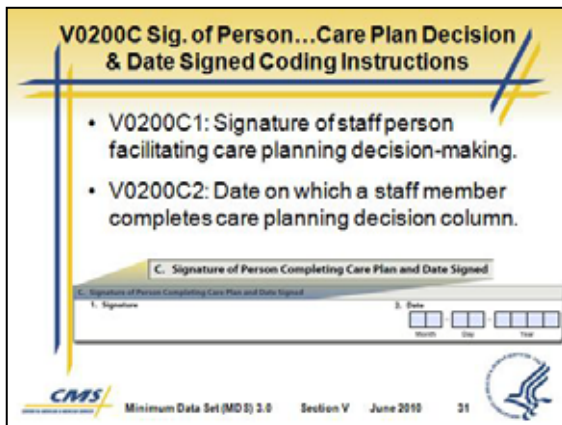


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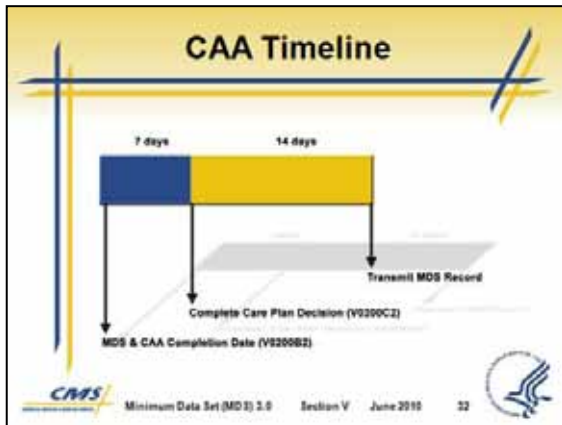
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- E. V0200B Signature of RN Coordinator for CAA Process and Date Signed
 1. V0200B1 allows for the signature of the RN coordinating the CAA process.
 2. V0200B2 documents the date that the RN coordinating the CAA process certifies that the CAAs have been completed.
 3. This date is considered the date of completion for the RAI.

- F. V0200C Signature of Person Completing Care Plan Decision and Date Signed
 1. V0200C1 allows for the signature of the staff member facilitating the care planning decision-making.
 2. Person signing should be the appropriate person as permitted under state law.
 3. V0200C2 documents the date on which a staff member completes V0200A Column B (care planning decision column).
 4. Column B is filled out after the care plan is completed.
 5. The signatures at V0200B1 and V0200C1 can be provided by the same person, if the person actually completed both functions.
 6. It is not a requirement that the same person complete both functions.

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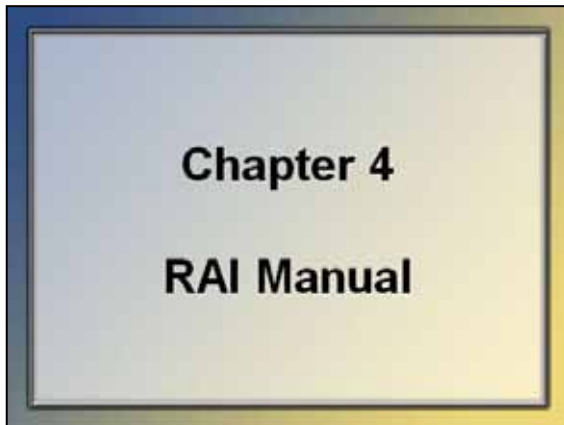
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G. CAA Timeline

1. The CAA process must be completed within the following timeframes:
 - a. No later than the 14th day of admission (admission date + 13 days) for an Admission assessment
 - b. Within 14 days of the Assessment Reference Date (A2300) for:
 - Annual assessment
 - Significant Change in Status assessment
 - Significant Correction to Prior Full assessment
 - c. The care plan must be completed within 7 days of the completion of the comprehensive assessment.
 - d. After completing the MDS and CAAs
 - e. As indicated by the date in V0200B2
2. The MDS 3.0 comprehensive assessment record must be transmitted to the QIES Assessment Submission and Processing (ASAP) system within 14 days of the V0200C2 date.

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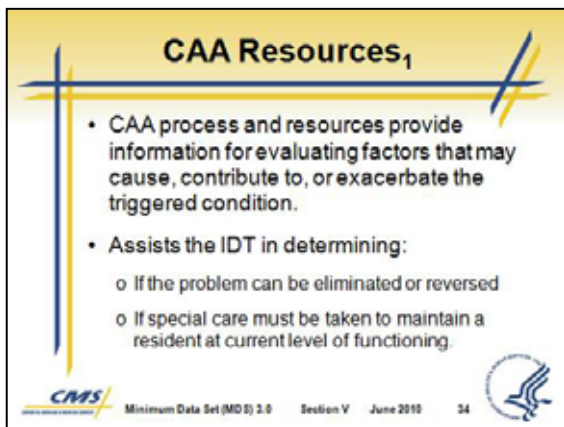
INSTRUCTIONAL GUIDANCE

V. Chapter 4 of the RAI Manual

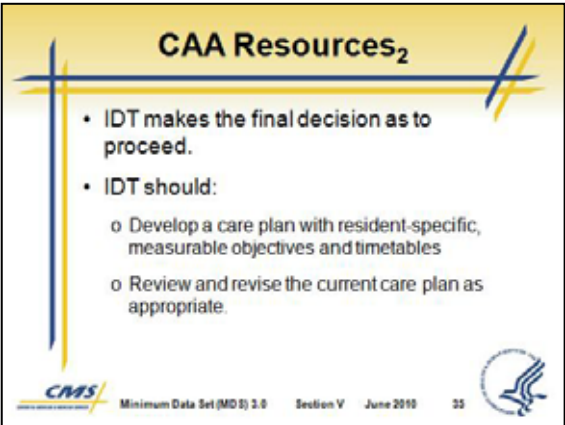
- A. Goal of CAAs is to guide the IDT through a structured comprehensive assessment of a resident's functional status.
- B. Functional status differs from medical or clinical status in that the whole of a person's life is looked at with the intent of assisting that person to function at his or her highest practicable level of well-being.
- C. Going through the RAI process will help staff set resident-centered measurable objectives in order to meet the physical, mental, and psychosocial needs of residents.
- D. Chapter 4 of the RAI Manual gives instructions on using the CAAs to assess conditions identified by the MDS triggering mechanism.

E. CAA Resources

1. The 20 CAAs in RAI cover the majority of areas that are addressed in a typical nursing home resident's care plan.
2. The triggers identify one or a combination of MDS item responses specific to a resident that alert the assessor to the resident's possible problems, needs, or strengths.
3. Also, indicates that clinical factors are present that may or may not represent a condition that should be addressed in the care plan.

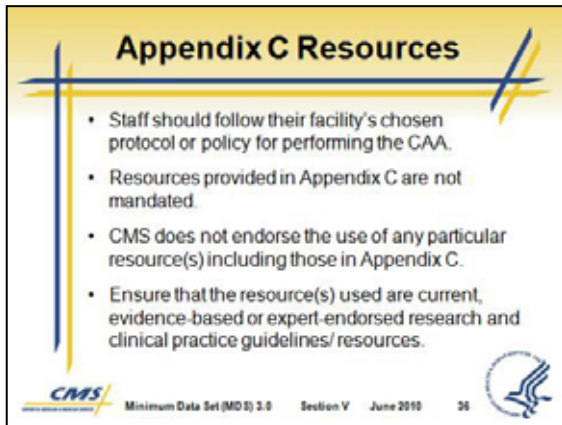


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SLIDES	INSTRUCTIONAL GUIDANCE
 <p>CAA Resources₂</p> <ul style="list-style-type: none"> • IDT makes the final decision as to proceed. • IDT should: <ul style="list-style-type: none"> ◦ Develop a care plan with resident-specific, measurable objectives and timetables ◦ Review and revise the current care plan as appropriate. <p><small>CMS Minimum Data Set (MDS) 3.0 Section V June 2010 35</small></p>	<ol style="list-style-type: none"> 4. The CAA process and resources provide information for evaluating factors that may cause, contribute to, or exacerbate the triggered condition. 5. Assists the IDT in determining if the problem can be eliminated or reversed, or if special care must be taken to maintain a resident at his/ her current level of functioning. 6. The IDT, including the resident, family, or resident representative, makes the final decision as to proceed to address the “triggered” condition on the care plan, which is clearly documented in the resident’s record. 7. Following decision to address a triggered condition, the IDT should develop a care plan with resident-specific measurable objectives and timetables and review and revise the current care plan as appropriate. 8. Staff may choose to combine related “triggered” conditions into a single care plan problem that will address the initial set of causal problems and related outcomes indentified in the CAA review.

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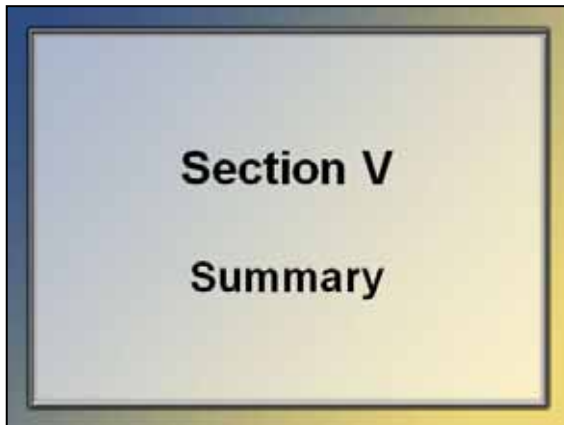
INSTRUCTIONAL GUIDANCE

F. Appendix C Resources

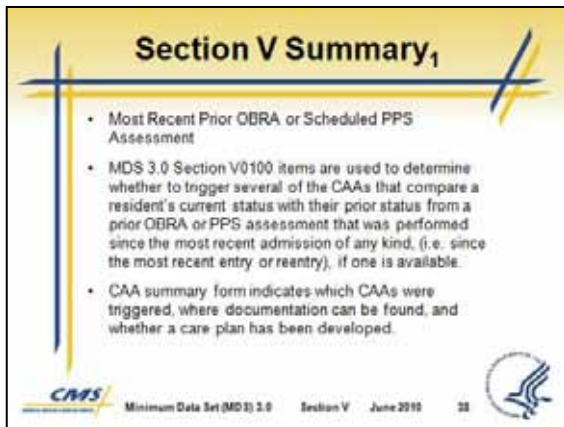
1. The specific resources or tools are found in Appendix C of the RAI manual.
 - a. Includes web-based & tool components
2. Following completion of the MDS, items and responses are reviewed to determine “triggered” care areas.
3. An additional/ further assessment of the care area(s) triggered is conducted using the care area(s) specific resource(s)
4. Staff should follow their facility’s chosen protocol or policy for performing the CAA.
5. The resources provided in Appendix C are not mandated nor does CMS endorse the use of any particular resource(s) including those provided in the appendix.
6. However, nursing homes should ensure that the resource(s) used are current, evidence-based or expert-endorsed research and clinical practice guidelines/ resources.
7. Care Area General Resources found at the end of Appendix C are not specific to any particular care area, they provide a general listing of known clinical practice guidelines and tools that may be used in completing the RAI CAA process.

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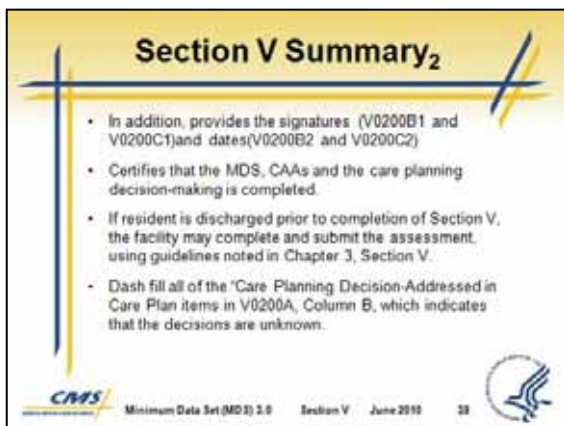
INSTRUCTIONAL GUIDANCE



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VI. Section V Summary

- A. Most Recent Prior OBRA or Scheduled PPS Assessment
- B. MDS 3.0 Section V0100 items are used to determine whether to trigger several of the CAAs that compare a resident's current status with their prior status from a prior OBRA or PPS assessment that was performed since the most recent admission of any kind, (i.e. since the most recent entry or reentry), if one is available.
- C. CAA summary form indicates which CAAs were triggered, where documentation can be found, and whether a care plan has been developed.
- D. In addition, provides the signatures (V0200B1 and V0200C1) and dates (V0200B2 and V0200C2)
- E. Certifies that the MDS, CAAs and the care planning decision-making is completed.
- F. If resident is discharged prior to completion of Section V, the facility may complete and submit the assessment, using guidelines noted in Chapter 3, Section V.

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	<p>G. Dash fill all of the “Care Planning Decision-Addressed in Care Plan items in V0200A, Column B, which indicates that the decisions are unknown.</p>