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.

Overview of Care Area Assessment (CAA)

Care Area Assessment (CAA)

- MDS does not constitute a comprehensive assessment.
- CAAs provide for a more comprehensive assessment.
- CAA process provides further assessment of triggered care areas.

CAA Purpose and Goals

- Purpose
  - Drive the development of an individualized care plan for the resident.
  - Form a critical link between MDS triggered care areas and care planning decisions.
- Goals:
  - Promote the highest practicable level of functioning for a resident through an assessment of triggered care areas from the MDS.
  - Determine if there is a problem and understand the causes/ contributing factors.

CAAs and RAPs

- CAAs (MDS 3.0) replace RAPs (MDS 2.0).
- There are 20 CAAs in Version 3.0 of the RAI.
  - New: Pain & Return to the Community Referral
- CAAs cover 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.

Triggering a Care Area Assessment

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

CAA Process

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

CAA(s) and Care Planning

- MDS and the CAA process identify care areas needing further assessment.
- IDT identifies relevant assessment information regarding the resident's status.
- IDT and resident/ family decide whether or not to develop a care plan for each of the triggered care areas.
- Chapter 4 of MDS manual provides detailed instructions on the CAA process and development of an individualized care plan.

Goal of Care Planning$_1$

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

Goal of Care Planning$_2$

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

CAA & Care Planning Documentation

- May occur anywhere in medical record.
- 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?

CAA & Care Planning Documentation

- Nature of issue/ condition
- Causes, contributing/ risk factors, complications
- Need for referrals and/ or further evaluation
- Consideration factors in developing care plan
- Resources used - Facilities may have written policies/ protocols/ standards of practice

Purpose of Section V

- Documents key information to support the CAA process:
  - Type of the most recent prior assessment
  - ARD for the most recent prior assessment
  - Summary Score for the BIMS from the most recent prior assessment
  - Total Severity Score for the Resident Mood Interview or Staff Assessment of Resident Mood for the most recent prior assessment
  - CAA summary for the current assessment

Item V0100

Items From the Most Recent Prior OBRA or PPS Assessment

V0100 Guidelines$_1$

- 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.

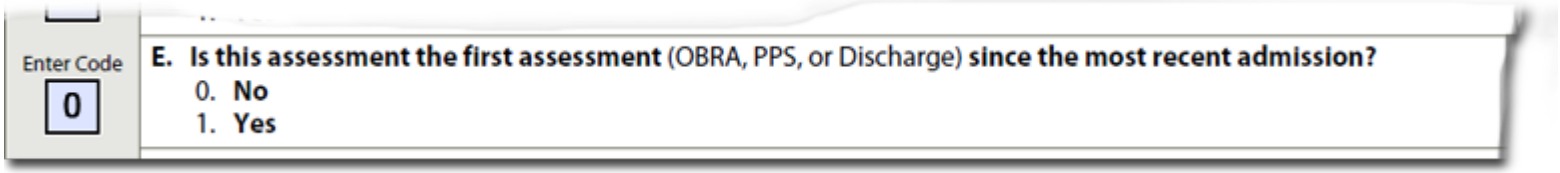
  o A0310E is coded **0. No**.

- Skip V0100A, B, C, D, E and F on the first assessment (OBRA or PPS) following the most recent admission of any kind.

  o A0310E is coded **1. Yes**.

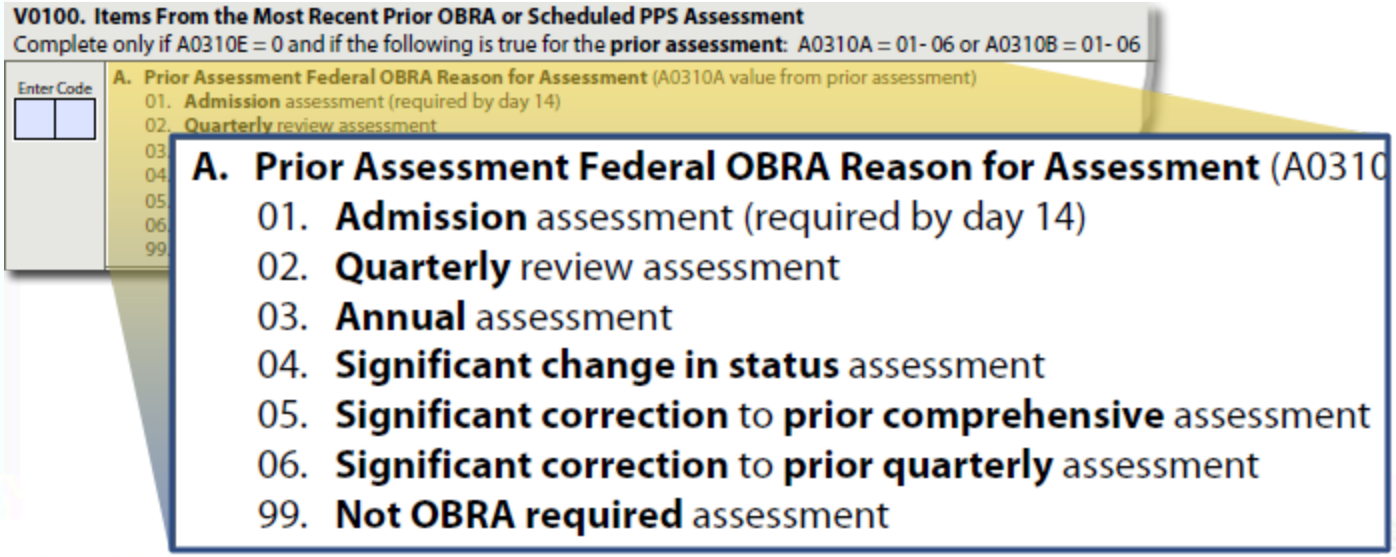
V0100 Guidelines$_2$

- 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.
  - Note that prior discharge or entry records are not considered or included in this list.



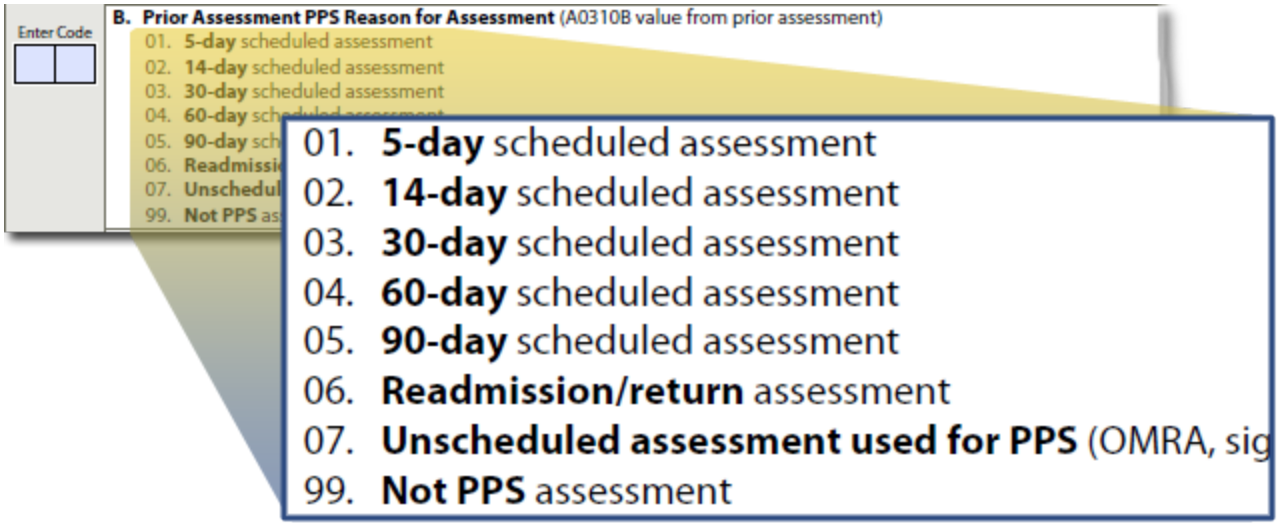
V0100A Coding Instructions

- Record the value for A0310A from the most recent prior OBRA or scheduled PPS assessment.
- One of the available values (**01** through **06** or **99**) must be selected.



V0100B Coding Instructions

- Record the value for A0310B from the most recent prior OBRA or scheduled PPS assessment.
- One of the available values (**01** through **07** or **99**) must be selected.



V0100A & V0100B Coding

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

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment

Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01- 06

Enter Code

A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

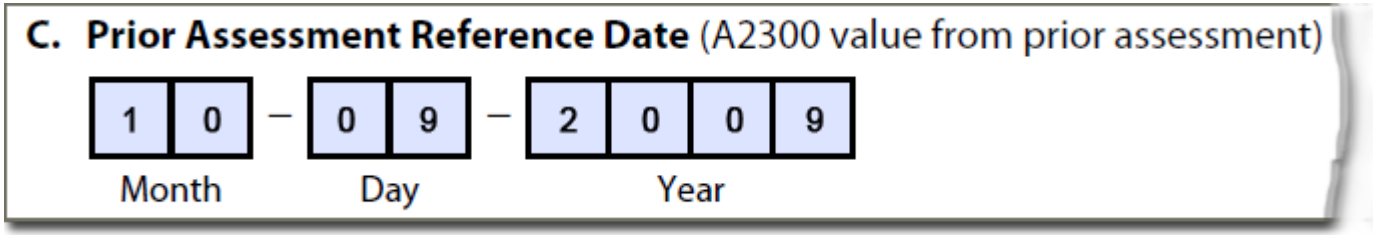
Enter Code

B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)

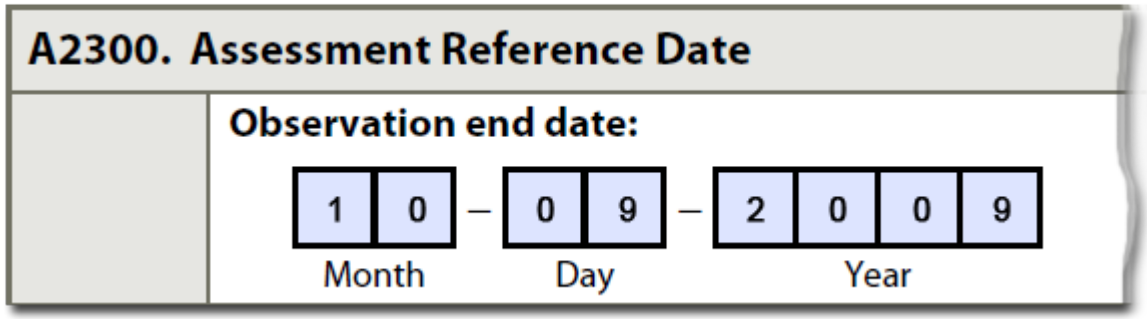
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
99. **Not PPS** assessment

V0100C Coding Instructions

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



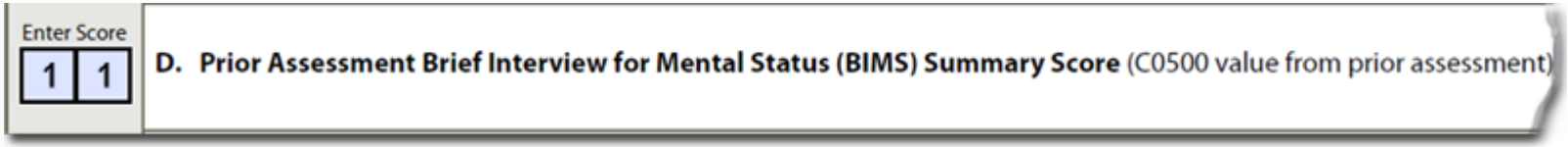
Item V0100C for the current assessment



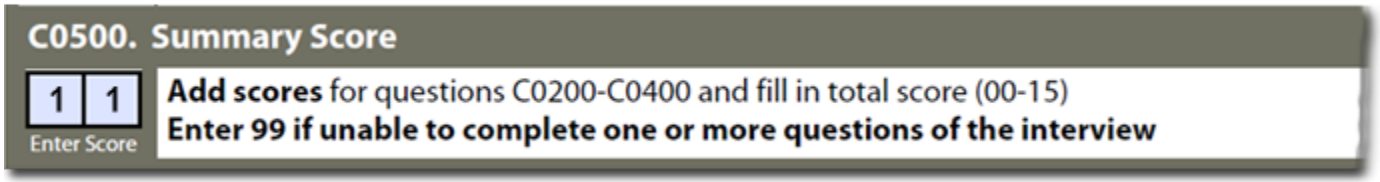
Item A2300 from the prior assessment

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.



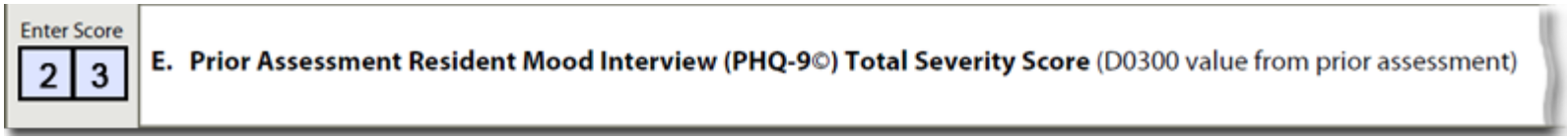
Item V0100D for the current assessment



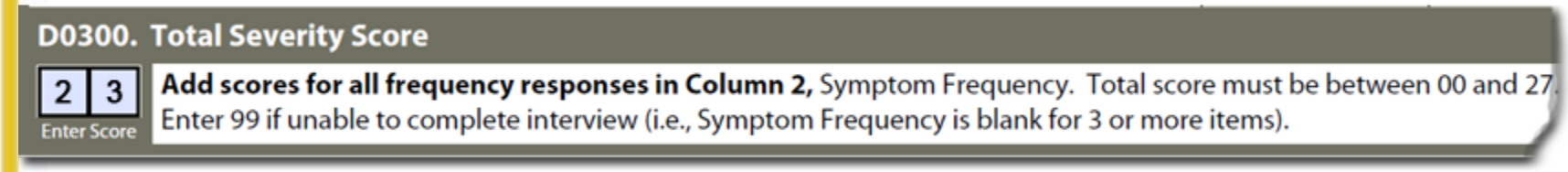
Item C0500 from the most recent prior assessment

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.



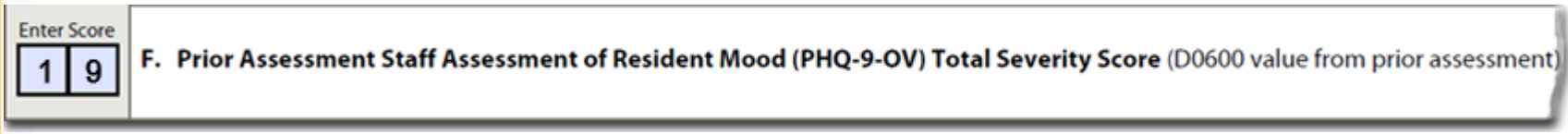
Item V0100E for the current assessment



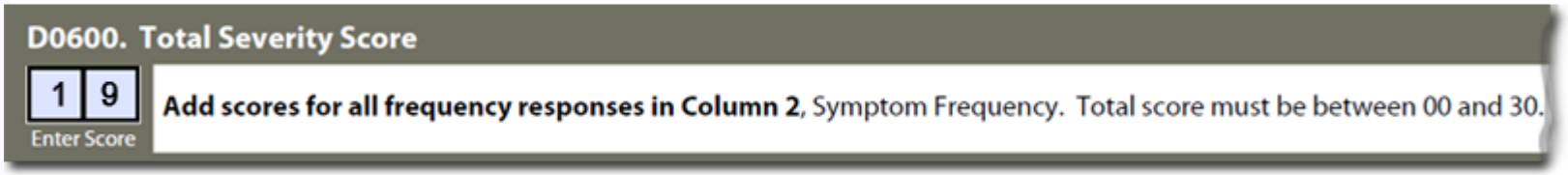
Item D0300 from the most recent prior assessment

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



Item D0600 from the most recent prior assessment

Item V0200

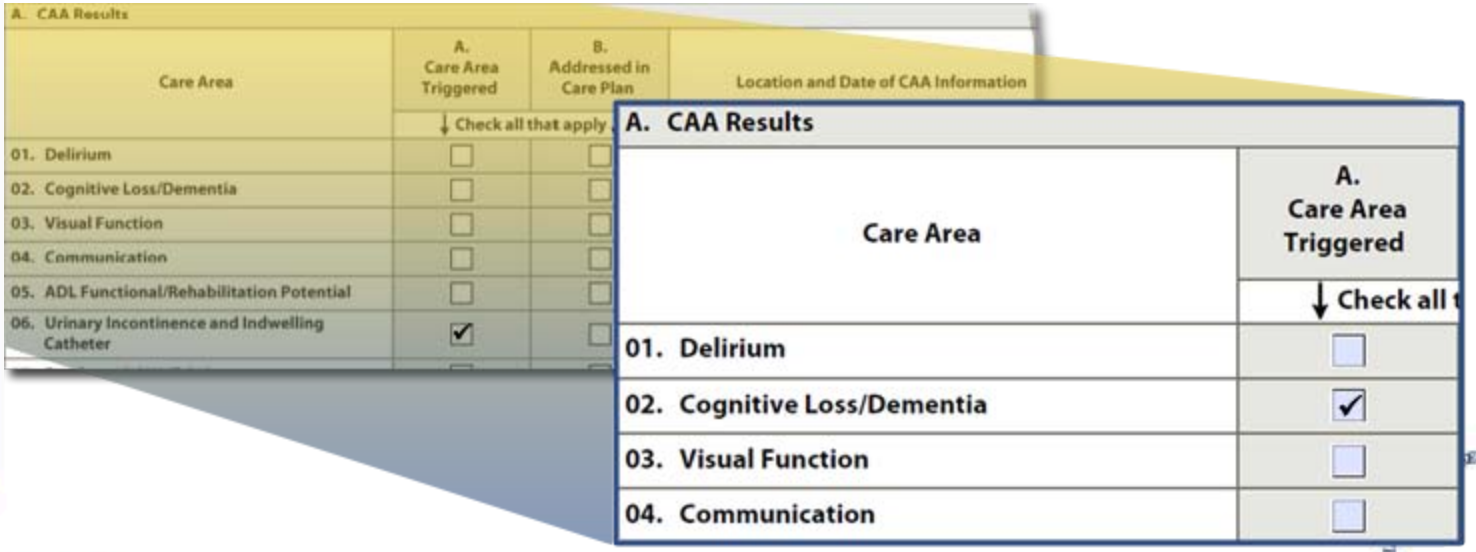
CAAs and Care Planning

V0200 CAAs and Care Planning

- Documents the following:
  - Which triggered care areas 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 staff use the RAI triggering mechanism to determine which problem care areas require review and additional assessment.
- Check triggered care areas in Column A.



A. CAA Results

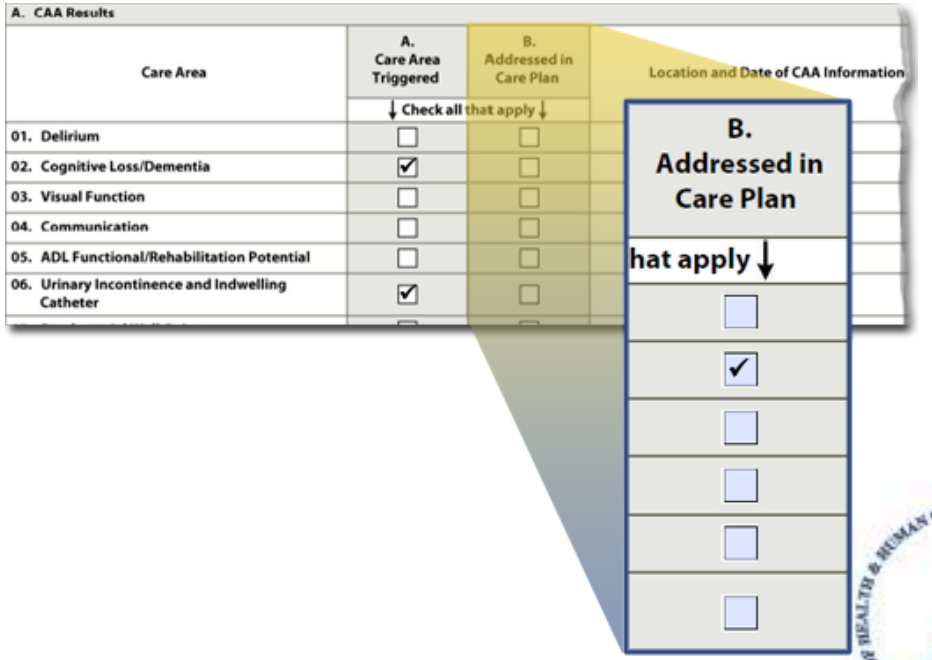
Care Area	A. Care Area Triggered (Check all that apply)	B. Addressed in Care Plan	Location and Date of CAA Information
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☑	☐	

A. CAA Results

Care Area	A. Care Area Triggered (Check all t
01. Delirium	☐
02. Cognitive Loss/Dementia	☑
03. Visual Function	☐
04. Communication	☐

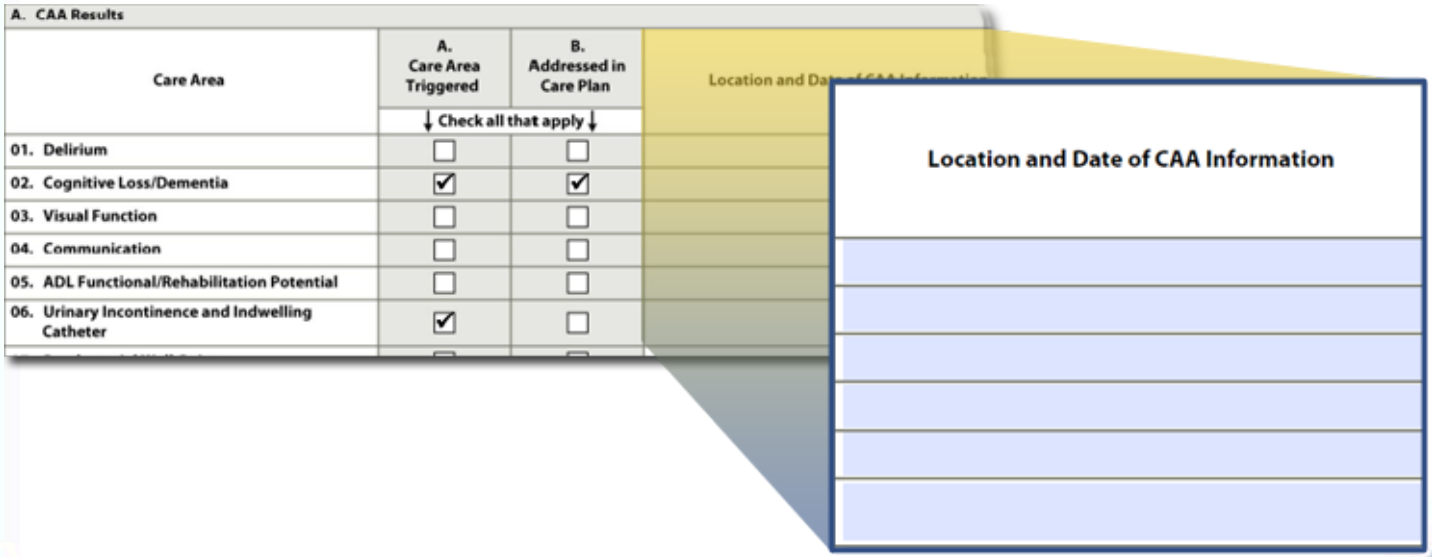
V0200A Column B Addressed In Care Plan Coding Instructions

- 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.
- Chapter 4 of the RAI Manual provides detailed instructions on the CAA process, care planning, and documentation.



A. CAA Results

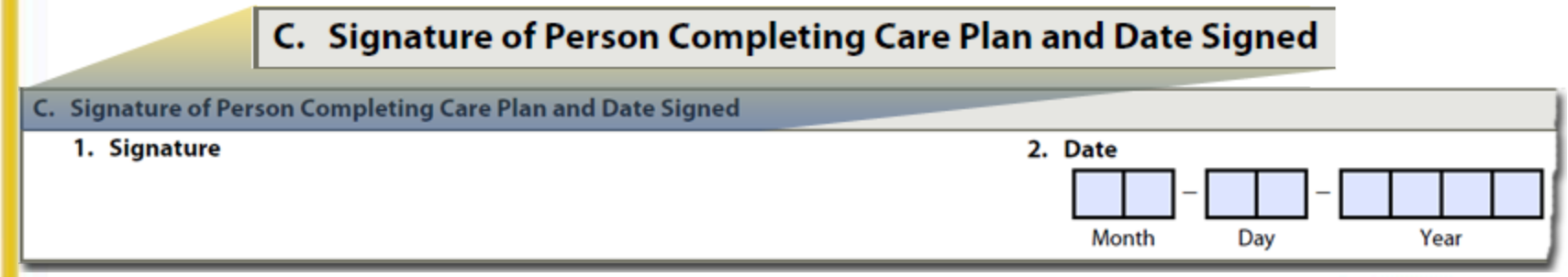
Care Area	A. Care Area Triggered	B. Addressed in Care Plan	Location and Date of CAA Information
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☑	☑	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☑	☐	

V0200B Signature of RN Coordinator & Date Signed Coding Instructions

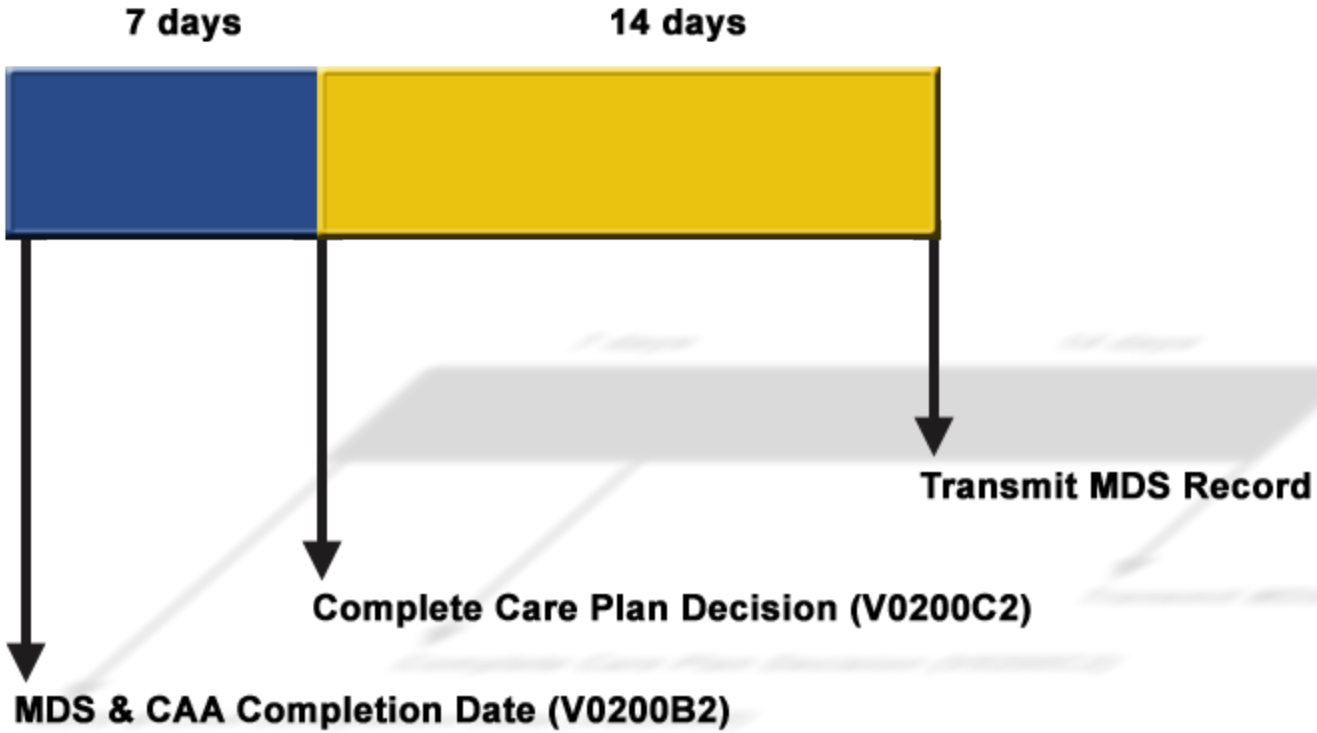
- V0200B1: Signature of the RN coordinating the CAA process.
- V0200B2: Date that the RN coordinating the CAA process certifies that the CAAs have been completed.

V0200C Sig. of Person…Care Plan Decision & Date Signed Coding Instructions

- V0200C1: Signature of staff person facilitating care planning decision-making.
- V0200C2: Date on which a staff member completes care planning decision column.



CAA Timeline



Chapter 4

RAI Manual

CAA Resources$_1$

- CAA process and resources provide information for evaluating factors that may cause, contribute to, or exacerbate the triggered condition.
- Assists the IDT in determining:
  - If the problem can be eliminated or reversed
  - If special care must be taken to maintain a resident at current level of functioning.

CAA Resources$_2$

- IDT makes the final decision as to proceed.
- IDT should:
  - Develop a care plan with resident-specific, measurable objectives and timetables
  - Review and revise the current care plan as appropriate.

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.
- Ensure that the resource(s) used are current, evidence-based or expert-endorsed research and clinical practice guidelines/ resources.