Regulation

F272

§483.20(b) Comprehensive Assessments

§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, using the *resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:*

F 272

- (i) Indentification and demographic information
- (ii) Customary routine
- (iii) Cognitive patterns
- (iv) Communication
- (v) Vision
- (vi) Mood and behavior patterns
- (vii) Psychological well-being
- (viii) Physical functioning and structural problems
- (ix) Continence
- (x) Disease diagnosis and health conditions
- (xi) Dental and nutritional status
- (xii) Skin Conditions
- (xiii) Activity pursuit
- (xiv) Medications
- (xv) Special treatments and procedures
- (xvi) Discharge potential
- ***(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS)***
- (xviii) Documentation of participation in assessment

Regulation

F278

§483.20(g) Accuracy of Assessment
The assessment must accurately reflect the resident's status.
Intent §483.20(g):
To assure that each resident receives an accurate assessment by staff that are qualified to assess relevant care areas and knowledgeable about the resident's status, needs, strengths, and areas of decline.

Interpretive Guidelines §483.20(j):

- MDS information serves as the clinical basis for care planning and delivery. With the introduction of additional uses of MDS information such as for payment rate setting and quality monitoring, MDS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process. A pattern within a nursing home of clinical documentation or of MDS assessment or reporting practices that result in higher RUG scores, untriggering *CAA(s), or unflagging QI(s), where the information does not accurately reflect the resident's status, may be indicative of payment fraud or avoidance of the quality monitoring process.*

F 278

Regulation

F279

§483.20(d) (A facility must..) use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

§483.20(k) Comprehensive Care Plans
(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

Interpretive Guidelines §483.20(k):

An interdisciplinary team, in conjunction with the resident resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team should show evidence in the CAA Summary or clinical record of the following:

F 279

- The resident's status in triggered *CAA areas;*
- The facility's rationale for deciding whether to proceed with care planning; and
- Evidence that the facility considered the development of care planning interventions for all *CAAs triggered by the MDS.*

Regulation

F280

§483.10(d)(3) – The resident has the right to -- unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

Interpretive Guidelines §483.10(d)(3)

An interdisciplinary team, in conjunction with the resident resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The interdisciplinary team should show evidence in the CAA Summary or clinical record of the following:

F 280

- The resident's status in triggered *CAA areas;*
- The facility's rationale for deciding whether to proceed with care planning; and
- Evidence that the facility considered the development of care planning interventions for all *CAAs triggered by the MDS.*

Interpretive Guidelines §483.20(k)(2):

The physician must participate as part of the interdisciplinary team, and may arrange with the facility for alternative methods, other than attendance at care planning conferences, of providing his/her input, such as one-on-one discussions and conference calls.

F 280

Resident Assessment Instrument (RAI) and Care Area Assessments (CAAs)

Assessment (MDS) → Decision-Making (CAA) → Care Plan Development → Care Plan Implementation → Evaluation

The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments.

It also provides a basis for additional assessment of potential issues, including related risk factors.

The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.

When implemented properly, The CAA process should help staff:

- Consider each resident as a whole, with characteristics and strengths that affect his or her capacity to function;
- Identify areas of concern that may warrant interventions;
- Develop, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident's condition, choices, and preferences and
- Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management.

What are the Care Area Triggers (CATs)?

Care Area Triggers (CATs) identify conditions that may require further evaluation because they impact conditions, or risks for the resident. Different CATs may have common causes, or associated issues and several CATs may be closely connected.

CATs are a "flag" for IDT members, indicating that the triggered care area ***needs to be assessed more completely*** prior to making care planning decisions. Further assessment of a triggered care area may identify causes, risk factors, and complications with that condition.

A risk factor increases the chances of having a negative outcome or complication. ***Recognizing the connection among these symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome.***

Conversely, failing to recognize the links and instead trying to address the triggers or MDS findings in isolation may have little if any benefit for the resident with complex or mixed causes of impaired behavior, cognition, and mood.

Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and possible approaches to improve function or minimize decline.

The MDS is a Screening Tool

But further assessment is needed to determine significance

BECAUSE MDS findings alone cannot guide

- - Effective clinical problem solving and
- - Effective decision making, that includes interventions

What are the Care Area Assessments?

The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings.

Interpreting and addressing the identified care areas is the basis of the Care Area Assessment process, and can help provide additional information for the development of an individualized care plan.

The CAA process does not mandate any specific tool for completing the further assessment of the triggered areas, nor does it provide any specific guidance on how to understand or interpret the triggered areas.

Instead, facilities are instructed to identify and use tools grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources.

When applying these evidenced-based resources, the use of sound clinical problem solving and decision making (critical thinking) skills is imperative.

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 other particular resource(s).
- Ensure that the resource(s) used are current, evidence-based or expert-endorsed research and clinical practice guidelines/resources.
- MDS 3.0 suggests that you get the Medical Director involved in choosing tools.

We use the CAA examples in Appendix C
How am I supposed to fill these out?

✓	**Medical problems** that can impact cognition	
☐	• Constipation (H0600), fecal impaction, diarrhea	
☐	• Diabetes (I2900)	
☐	• Thyroid Disorder (I3400)	
☐	• Congestive heart failure (I0600)/other cardiac diseases (I0300, I0400)	
☐	• Respiratory problems (I6200, I6300, I2000, I2200, I8000)/decreased oxygen saturation	
☐	• Cancer (I0100)	
☐	• Liver disease (I1100, I2400, I8000 and record)	
☐	• Renal failure (I1500)	
☐	• Psychiatric or mood disorder (I5700-I6100)	
☐	• Electrolyte imbalance (from record)	
☐	• Poor nutrition (I5600) or hydration status (J1550C) (and from record)	
☐	• End of life (Hospice O0100K and from record)	

Step 1: After completing the MDS, look and see what triggered

Step 2: For any triggered care area, assess the resident using the care area-specific resources.

Step 3: Check the box in the left column if the item is present for this resident. ***Some of this information will be on the MDS - some will not.***

Step 4: In the right column you can provide a summary of supporting documentation regarding the basis or reason for checking a particular item or items. This could include the location and date of that information, symptoms, possible causal and contributing factor for item checked, etc.

Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		Care Plan Considerations
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Step 5: Get input from resident and/or family regarding the care area.

Step 6: Analyze the findings in the context of their relationship to the care area. This should include a review of indicators and supporting documentation, including symptoms and contributing factors, related to this care area.

Step 7: Draw conclusions about the causal/contributing factors and effect(s) on the resident, and document these conclusions in the Analysis of Findings section.

Step 8: Decide whether referral to other disciplines is warranted and document this decision.

Step 9: In the Care Plan Considerations section, document whether a care plan for the triggered care area will be developed and the reason(s) why or why not.

Step 10: Information in the *Supporting Documentation column can be used to populate the Location and Date of CAA Information column in Section V, Item V0200A (CAA Results) – for e.g. "See Delirium CAA 4/30/15, H&P dated 4/18/15*

For Example the Mood CAA

Asks for information about:

- 19 'clinical issues' such as cardiac disease, renal impairment, et cetera
- 21 medication classes or specific meds
- 5 lab values

Can I get a little HELP here???

And What Can Help Do This?

- Interdisciplinary discussion
- Policies/procedures for doing CAA problem analysis that have been designed by the facility and integrated into the P&P
- Having staff see 'the big picture' and work together to meet patient needs

Care Area Assessment Documentation

"CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions." RAI Manual, page 4 - 6

Care Area Assessment Documentation……

For each triggered CAA describe:

1. Identified nature of the condition and why it's a problem
2. Complications caused by the care area for this person
3. Risk factors related to the condition that affect the decision to care plan/or not to care plan
4. Factors to consider in developing *individualized* care plan interventions, including decision to care plan or not to care plan
5. The need for additional evaluation by the physician and other health professionals, as appropriate;
6. The resource(s), or assessment tool(s) used for decision-making

RAI Manual, page 4-7 (Chap.4)

Care Area Assessment Documentation

"Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record; for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc. Nursing homes should use a format that provides the information as outlined in this manual and the State Operations Manual (SOM)."

RAI Manual, page 4-7 (Chap.4)

Key to Writing Good CAAs

- **Paint a picture of the resident's status**
- **Talk about the resident's *individual* condition**
- **The better all staff know the resident, the better able they will be to provide and monitor adequate care and services to help that individual reach their highest practicable level of well-being**

A Smooth Transition to the Care Plan

Assessment (MDS)	Decision-Making (CAA)	Care Plan Development	Care Plan Implementation	Evaluation

A good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan.

The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.

Care Planning

- **No required format or structure**
- **Must have measurable goals and time tables**
  - **Goals should have a subject, verb, modifier, time frame and goal**

Example:

Subject	Verb	Modifiers	Time Frame	Goal
Mr.Jones	will walk	50 feet daily with the help of one NA	in the next 30 days	in order to maintain mobility, continence, and to eat in the dining room

The Overall CP Should Be Oriented Toward:

1. Preventing avoidable declines in functioning or clarifying why another goal takes precedence (e.g. palliative care for end of life).
2. Managing risk factors or indicating the limits of such interventions.
3. Ways to try to preserve and build upon resident strengths.
4. Applying current standards of practice in care planning.
5. Evaluating measurable objectives, timetables and outcomes.
6. Respecting the resident's right to decline treatment.
7. Offering alternative treatments, as applicable.

(cont.) CP Should Be Oriented Toward:

8. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities.
9. Involving resident, resident's family and other resident representatives as appropriate.
10. Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs.
11. Involving the direct care staff with the care planning process relating to the resident's expected outcomes.
12. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.

Steps / Objectives	Key Tasks
Assessment *Essential info about the person*	• Identify and collect information to define the individual's conditions, strengths, needs, risks, problems and prognosis • Obtain a medical and personal history • Perform a physical assessment
Problem *The individual's problems, risks and concerns*	• Identify any current consequences and complications of the situation and underlying condition • Clearly state the individual's issues, physical , functional and psychosocial strengths, problems, needs and concerns • Define significant risk factors

Steps / Objectives	Key Tasks
Diagnosis and Analysis *Physical, functional and psychosocial causes / risks and how they are inter-related*	• Factors contributing to current dysfunctions, disabilities or risks • Pertinent evaluations and diagnostic tests • and test results and how they are related • How interventions will affect outcomes
Goals / Objectives *Purpose of care and interventions as well as criteria to use in determining if objectives are met*	• Clarify prognosis • Define the individual's goals • Criteria for meeting goals

Steps / Objectives	Key Tasks
Select Interventions *Interventions and treatments to address function, psychosocial needs and risks*	• How proposed interventions are expected to impact outcome and attain goals for the individual • Clarify how to evaluate interventions for effectiveness and possible adverse consequences
Monitoring *Measure progress toward goals and modify approaches as needed*	• Identify the individual's response to interventions and factors affecting progress toward achieving goals • Define when to modify interventions • Review adverse consequences and adjust interventions PRN • Identify when objectives are achieved

Summary: Decision Making / Documentation

- Formulate clear picture of the resident
- Create a resident-centered care plan
  - Based on conclusions from clinical problem solving and decision making process AND
  - Resident preferences, personal goals
- Document basis for conclusions
  - Not just conclusions

Let's Do One Together

Meet James

Some things we know about him……

and we will create the rest of the story

* Parkinson's disease, dementia, depression, GERD, anemia, A-Fib, and HTN
* Admitted December 2012
* 86 y.o. Retired college professor, wife died in 1999, son lives in MN
* Good sense of humor, zest for living, sleeps well
* Aware of progression and accepting of Parkinson DX
* Significant friend visits weekly & spends time w/one resident friend
* Enjoys golf, current events, his church family,
* "Forgets words" but able to communicate needs, has hearing aids
* Ambulatory with a walker, has a Hx of falls but none in last 30 days

Key to Writing Good CAAs

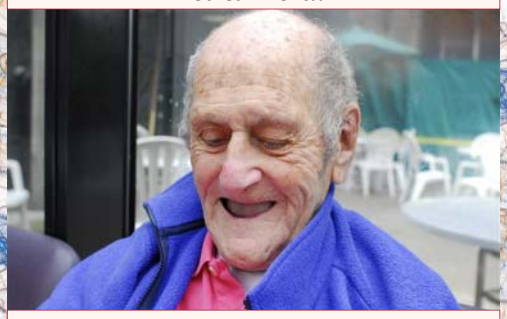
- **Paint a picture of the resident's status**
- **Talk about the resident's *individual* condition – the care plan must be *individualized***
- **The better all staff know the resident, the better able they will be to provide and monitor adequate care and services to help that individual reach their highest practicable level of well-being**

Care Area Assessment Documentation……

For each triggered CAA describe:

1. Identified nature of the issue/condition and why it is a problem
2. Complications affecting or caused by the care area for this person
3. Risk factors related to the condition that affect the decision to care plan/or not to care plan
4. Factors to consider in developing *individualized* care plan interventions, including decision to care plan or not to care plan
5. The need for additional evaluation by the attending physician and other health professionals, as appropriate;
6. The resource(s), or assessment tool(s) used for decision-making

You Can Do It!!



The resident's quality of life will be better for your efforts