SECTION V: CARE AREA ASSESSMENT (CAA) SUMMARY

Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning.

There are 20 CAAs in Version 3.0 of the RAI, which includes the addition of "Pain" and "Return to the Community Referral." These CAAs cover the majority of care areas known to be problematic for nursing home residents. The Care Area Assessment (CAA) process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directs facility staff and health professionals to evaluate triggered care areas.

The interdisciplinary team (IDT) then identifies relevant assessment information regarding the resident's status. After obtaining input from the resident, the resident's family, significant other, guardian, or legally authorized representative, the IDT decides whether or not to develop a care plan for triggered care areas. Chapter 4 of this manual provides detailed instructions on the CAA process and development of an individualized care plan.

Whereas the MDS identifies actual or potential problem areas, the CAA process provides for further assessment of the triggered areas by guiding staff to look for causal or confounding factors, some of which may be reversible. It is important that the CAA documentation include the causal or unique risk factors for decline or lack of improvement. The plan of care then addresses these factors, with the goal of promoting the resident's highest practicable level of functioning: (1) improvement where possible, or (2) maintenance and prevention of avoidable declines. Documentation should support your decision making regarding whether to proceed with a care plan for a triggered CAA and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record, e.g., progress notes, consults, flowsheets, etc.

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

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

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. None of the above

Enter Code ☐☐

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

01. **5-day** scheduled assessment
08. **IPA** - Interim Payment Assessment
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

Enter Score ☐☐

D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

Enter Score ☐☐

E. Prior Assessment Resident Mood Interview (PHQ-2 to 9©) Total Severity Score (D0160 value from prior assessment)

Enter Score ☐☐

F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assesment)

Item Rationale

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. The values of these items 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. 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 (i.e., when A0310E = 1, Yes). Complete these items only if a prior assessment has been completed since the most recent admission of any kind to the facility (i.e., when A0310E = 0, No) and if the prior assessment is an OBRA or a scheduled PPS assessment. 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.

Coding Instructions for V0100A, Prior Assessment Federal OBRA Reason for Assessment (A0310A Value from Prior Assessment)

- Record in V0100A the value for A0310A (Federal OBRA Reason for Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 through 06 or 99) must be selected.

V0100: Items From the Most Recent Prior OBRA or *Scheduled* PPS Assessment (cont.)

Coding Instructions for V0100B, Prior Assessment PPS Reason for Assessment (A0310B Value from Prior Assessment)

- Record in V0100B the value for A0310B (PPS Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 or 08 or 99) must be selected.

  Note: The values for V0100A and V0100B cannot both be 99, indicating that the prior assessment is neither an OBRA nor a PPS assessment. If the value of V0100A is 99 (None of the above), then the value for V0100B must be 01 or 08, indicating a PPS assessment. If the value of V0100B is 99 (None of the above), then the value for V0100A must be 01 through 06, indicating an OBRA assessment.

Coding Instructions for V0100C, Prior Assessment Reference Date (A2300 Value from Prior Assessment)

- Record in V0100C the value of A2300 (Assessment Reference Date) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details).

Coding Instructions for V0100D, Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 Value from Prior Assessment)

- Record in V0100D, the value for C0500 Mental Status (BIMS) Summary Score from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident improvement or decline in the Delirium care area.

Coding Instructions for V0100E, Prior Assessment Resident Mood Interview (PHQ-*2 to* 9©) Total Severity Score (D0*16*0 Value from Prior Assessment)

- Record in V0100E the value of D0*16*0 (Resident Mood Interview [PHQ-*2 to* 9©] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

Coding Instructions for V0100F, Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV©) Total Severity Score (D0600 Value from Prior Assessment)

- Record in V0100F the value for item D0600 (Staff Assessment of Resident Mood [PHQ-9-OV©] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

V0200: CAAs and Care Planning

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ 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	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature

2. Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature

2. Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

V0200: CAAs and Care Planning (cont.)

Item Rationale

- Items V0200A 01 through 20 document which triggered care areas require further assessment, decision as to whether or not a triggered care area is addressed in the resident care plan, and the location and date of CAA documentation. The CAA Summary documents the interdisciplinary team's and the resident, resident's family or representative's final decision(s) on which triggered care areas will be addressed in the care plan.

Coding Instructions for V0200A, CAAs

- Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.
- For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed. 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 this manual provides detailed instructions on the CAA process, care planning, and documentation.

Coding Instructions for V0200B, Signature of RN Coordinator for CAA Process and Date Signed

V0200B1, Signature

- Signature of the RN coordinating the CAA process.

V0200B2, Date

- Date that the RN coordinating the CAA process certifies that the CAAs have been completed. The CAA review must be completed no later than the 14th day of admission (admission date + 13 calendar days) for an Admission assessment and within 14 days of the Assessment Reference Date (A2300) for an Annual assessment, Significant Change in Status Assessment, or a Significant Correction to Prior Comprehensive Assessment. This date is considered the date of completion for the RAI.

V0200: CAAs and Care Planning (cont.)

Coding Instructions for V0200C, Signature of Person Completing Care Plan Decision and Date Signed

V0200C1, Signature

- Signature of the staff person facilitating the care planning decision-making. Person signing does not have to be an RN.

V0200C2, Date

- The date on which a staff member completes the Care Planning Decision column (V0200A, Column B), which is done after the care plan is completed. The care plan must be completed within 7 days of the completion of the comprehensive assessment (MDS and CAAs), as indicated by the date in V0200B2.
- Following completion of the MDS, CAAs (V0200A, Columns A and B) and the care plan, the MDS 3.0 comprehensive assessment record must be transmitted to *i*QIES within 14 days of the V0200C2 date.

Clarifications:

- The signatures at V0200B1 and V0200C1 can be provided by the same person, if the person actually completed both functions. However, it is not a requirement that the same person complete both functions.
- If a resident is discharged prior to the completion of Section V, a comprehensive assessment may be in progress when a resident is discharged. Although the resident has been discharged, the facility may complete and submit the assessment. **The following guidelines apply to completing a comprehensive assessment* when the resident has been discharged**:

  1. Complete all required MDS items from Section A through Section Z and indicate the date of completion in Z0500B. Encode and verify these items.
  2. Complete the care area triggering process by checking all triggered care areas in V0200A, Column A.
  3. Sign and enter the date the CAAs were completed at V0200B1 and V0200B2.
  4. Dash fill all of the "Care Planning Decision" items in V0200A, Column B, which indicates that the decisions are unknown.
  5. Sign and enter the date that care planning decisions were completed at V0200C1 and V0200C2. Use the same date used in V0200B2.
  6. Submit the record.

  *Please see Chapter 2 for additional detailed instructions regarding options for when residents are discharged prior to completion of the RAI.