

# **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: to drive the development of an individualized care plan for the resident.
- 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
- Triggered care areas form a critical link between MDS and care planning decisions.

# 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 à 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

- Nursing homes use results of the MDS and the CAA process to identify care areas needing further assessment.
- The interdisciplinary team (IDT) identifies relevant assessment information regarding the resident's status.
- IDT decides 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<sub>1</sub>

- 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<sub>2</sub>

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

# CAA & Care Planning Documentation<sub>1</sub>

- 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<sub>2</sub>

- 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<sub>1</sub>

- 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.
  - 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.
  - A0310E is coded **1. Yes.**

# V0100 Guidelines<sub>2</sub>

- Complete V0100 only if:
  - o A prior assessment has been completed since the most recent admission to the facility.
  - o The prior assessment was a Federal OBRA assessment **OR** a PPS assessment.
  - o Note that prior discharge or entry records are not considered or included in this list.

Enter Code	<b>E. Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission?</b>
<input type="text" value="0"/>	0. No 1. Yes

# 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.

## 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)
<input type="text"/>	01. Admission assessment (required by day 14)
<input type="text"/>	02. Quarterly review assessment
<input type="text"/>	03. Annual assessment
<input type="text"/>	04. Significant change in status assessment
<input type="text"/>	05. Significant correction to prior comprehensive assessment
<input type="text"/>	06. Significant correction to prior quarterly assessment
<input type="text"/>	99. Not OBRA required assessment

# 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.

Enter Code

<input type="text"/>	<input type="text"/>
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**B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)**

01. 5-day scheduled assessment	01. <b>5-day</b> scheduled assessment
02. 14-day scheduled assessment	02. <b>14-day</b> scheduled assessment
03. 30-day scheduled assessment	03. <b>30-day</b> scheduled assessment
04. 60-day scheduled assessment	04. <b>60-day</b> scheduled assessment
05. 90-day scheduled assessment	05. <b>90-day</b> scheduled assessment
06. Readmission/return assessment	06. <b>Readmission/return</b> assessment
07. Unscheduled assessment used for PPS (OMRA, sig	07. <b>Unscheduled assessment used for PPS</b> (OMRA, sig
99. Not PPS assessment	99. <b>Not PPS</b> assessment

# V0100A & V0100B Coding

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

<b>V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment</b>	
Complete only if A0310E = 0 and if the following is true for the <b>prior assessment</b> : A0310A = 01-06 or A0310B = 01-06	
Enter Code <input type="text"/>	<b>A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)</b> 01. <b>Admission</b> assessment (required by day 14) 02. <b>Quarterly</b> review assessment 03. <b>Annual</b> assessment 04. <b>Significant change in status</b> assessment 05. <b>Significant correction to prior comprehensive</b> assessment 06. <b>Significant correction to prior quarterly</b> assessment 99. <b>Not OBRA required</b> assessment
Enter Code <input type="text"/>	<b>B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)</b> 01. <b>5-day</b> scheduled assessment 02. <b>14-day</b> scheduled assessment 03. <b>30-day</b> scheduled assessment 04. <b>60-day</b> scheduled assessment 05. <b>90-day</b> scheduled assessment 06. <b>Readmission/return</b> assessment 07. <b>Unscheduled assessment used for PPS</b> (OMRA, significant or clinical change, or significant correction assessment) 99. <b>Not PPS</b> assessment

# V0100C Coding Instructions

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

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

1 0 – 0 9 – 2 0 0 9  
Month Day Year

## Item V0100C for the current assessment

### A2300. Assessment Reference Date

Observation end date:

1 0 – 0 9 – 2 0 0 9  
Month Day Year

## 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.

Enter Score 1 1	D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)
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## Item V0100D for the current assessment

C0500. Summary Score	
1 1	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if unable to complete one or more questions of the interview
Enter Score	

## 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.

Enter Score	<input type="text" value="2"/> <input type="text" value="3"/>	E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)
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## Item V0100E for the current assessment

### D0300. Total Severity Score

Enter Score	<input type="text" value="2"/> <input type="text" value="3"/>	Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).
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## 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.

Enter Score

1 9

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

## Item V0100F for the current assessment

D0600. Total Severity Score

1 9

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

## Item D0600 from the most recent prior assessment

**Item V0200**

**CAAs and Care Planning**

# V0200 CAAs and Care Planning

- Documents the following:
  - o Which care areas triggered and require further assessment
  - o Whether or not a care area is addressed in the resident care plan
  - o 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 uses the RAI triggering mechanism to determine which problem care areas require review and additional assessment.
- Triggered care areas are checked in Column A.

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	<input type="checkbox"/>	<input type="checkbox"/>	
02. Cognitive Loss/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	
05. ADL Functional/Rehabilitation Potential	<input type="checkbox"/>	<input type="checkbox"/>	
06. Urinary Incontinence and Indwelling Catheter	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

A. CAA Results	
Care Area	A. Care Area Triggered
	↓ Check all that apply
01. Delirium	<input type="checkbox"/>
02. Cognitive Loss/Dementia	<input checked="" type="checkbox"/>
03. Visual Function	<input type="checkbox"/>
04. Communication	<input type="checkbox"/>

# 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.

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	<input type="checkbox"/>	<input type="checkbox"/>	
02. Cognitive Loss/Dementia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	
05. ADL Functional/Rehabilitation Potential	<input type="checkbox"/>	<input type="checkbox"/>	
06. Urinary Incontinence and Indwelling Catheter	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

B. Addressed in Care Plan
What apply ↓
<input type="checkbox"/>
<input checked="" type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

# 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	<input type="checkbox"/>	<input type="checkbox"/>	
02. Cognitive Loss/Dementia	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	
05. ADL Functional/Rehabilitation Potential	<input type="checkbox"/>	<input type="checkbox"/>	
06. Urinary Incontinence and Indwelling Catheter	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

**Location and Date of CAA Information**

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# 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.

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

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

1. Signature

2. Date

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year		

# 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.

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

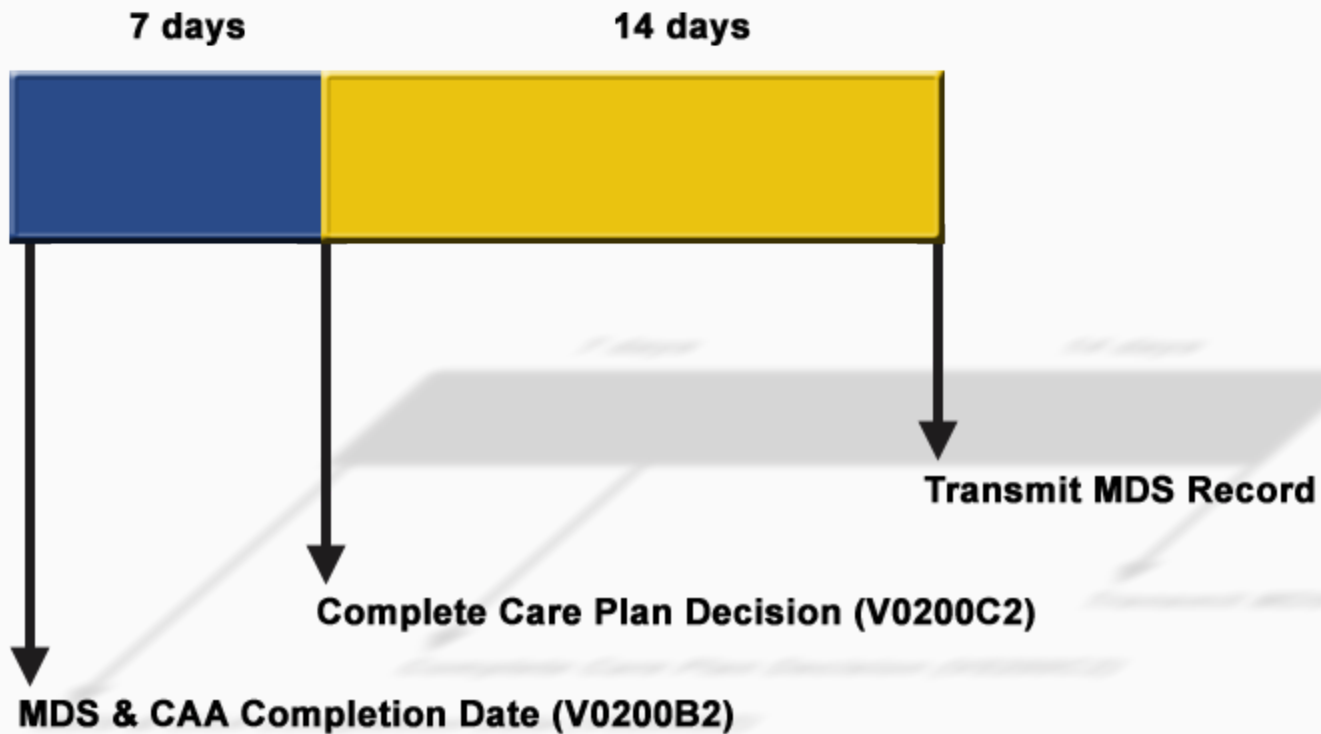
### C. Signature of Person Completing Care Plan and Date Signed

1. Signature

2. Date

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year		

# CAA Timeline



# **Chapter 4**

## **RAI Manual**

# CAA Resources<sub>1</sub>

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

# CAA Resources<sub>2</sub>

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

# **Section V**

## **Summary**

# Section V Summary<sub>1</sub>

- Most Recent Prior OBRA or Scheduled PPS Assessment
- 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.
- CAA summary form indicates which CAAs were triggered, where documentation can be found, and whether a care plan has been developed.

# Section V Summary<sub>2</sub>

- In addition, provides the signatures (V0200B1 and V0200C1) and dates (V0200B2 and V0200C2)
- Certifies that the MDS, CAAs and the care planning decision-making is completed.
- 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.
- Dash fill all of the “Care Planning Decision-Addressed in Care Plan items in V0200A, Column B, which indicates that the decisions are unknown.