

*This Way Forward*




## Care Area Assessment (CAA) Documentation for Activity and Social Services Staff

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## Session Objectives

- Use CAAs to apply assessment data collected on the MDS.
- Write accurate, meaningful, and individualized CAA documentation.
- Use CAA documentation to explain the basis for the care plan.
- Source of information: CMS's RAI Version 3.0 Manual



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## The Minimum Data Set (MDS)

- The MDS is a starting point.
- It is a standardized instrument used to assess nursing home residents.
- It is a collection of basic physical, functional, and psychosocial information about residents.



## MDS Triggers

- The MDS triggers identify *actual or potential* areas of concern.
- We must further assess triggered areas of concern in order to identify whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment.
- These conclusions then provide the basis for developing an individualized care plan for each resident.





## The CAA Process Framework

- A framework for guiding the review of triggered areas, clarification of a resident's functional status, and related causes of impairments.
- 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.

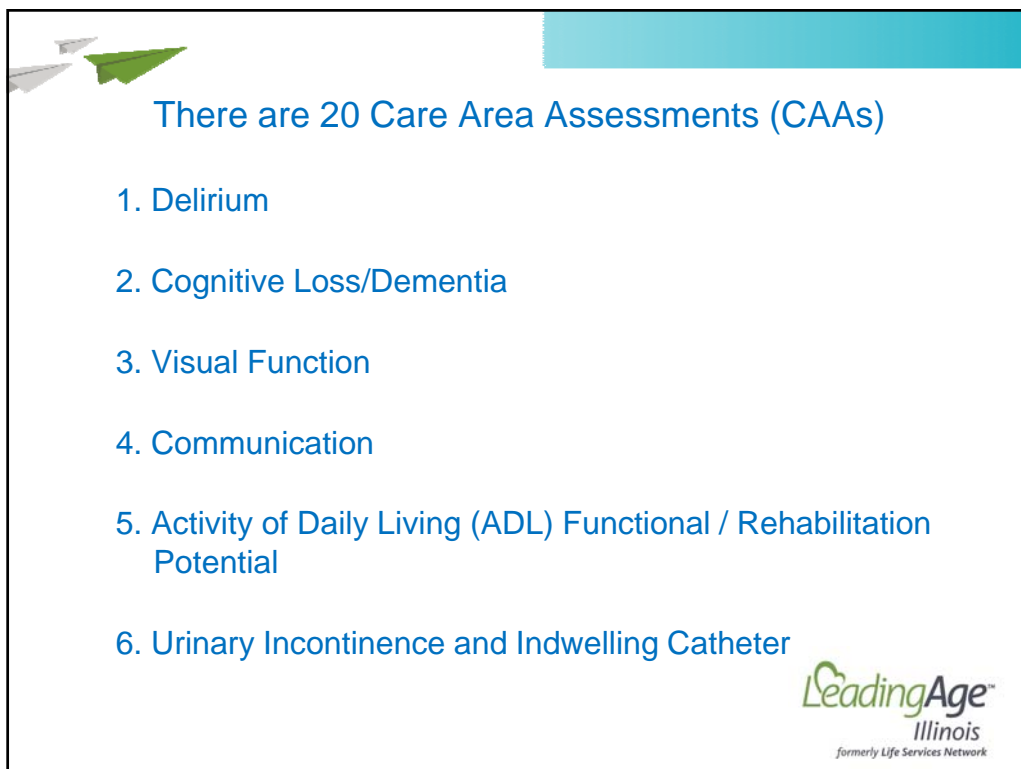
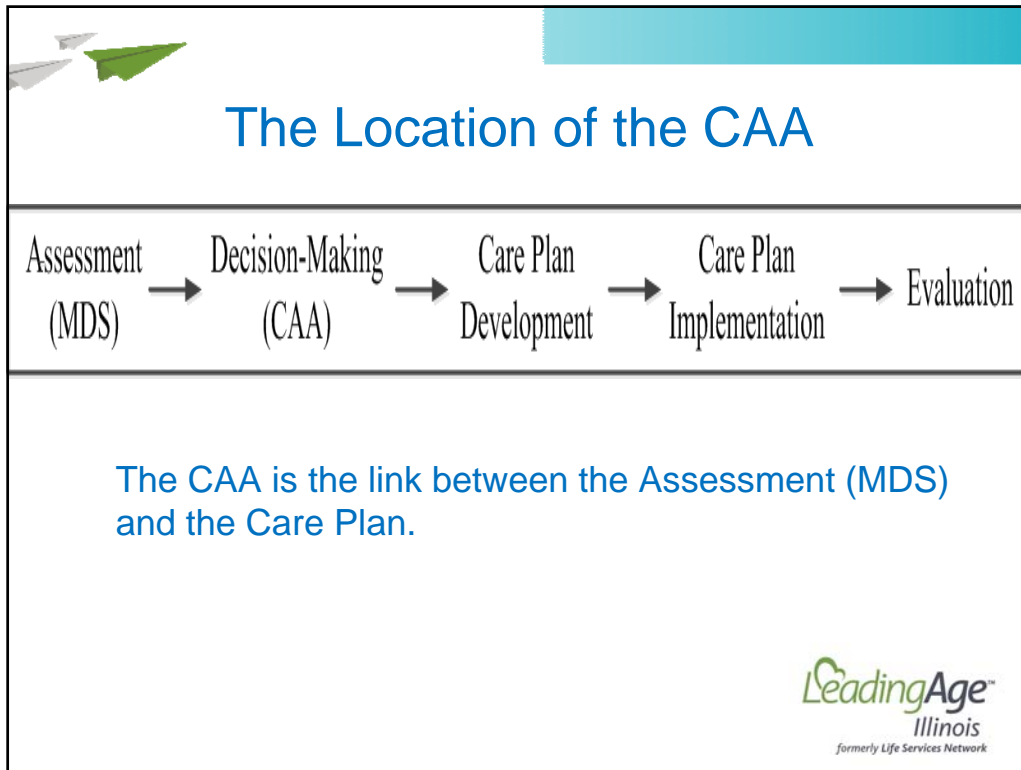
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## How the CAA Process Helps Staff

- Consider each resident as a whole, with unique 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 for interventions; 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.

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There are 20 Care Area Assessments (CAAs)

7. Psychosocial Well-Being
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes



• There are 20 Care Area Assessments (CAAs)

14. Dehydration/Fluid Maintenance
15. Dental Care
16. Pressure Ulcer
17. Psychotropic Medication Use
18. Physical Restraints
19. Pain
20. Return to Community Referral





## CAAs Commonly Completed by Activity and Social Services Staff

2. Cognitive Loss/Dementia
4. Communication
7. Psychosocial Well-Being
8. Mood State
9. Behavioral Symptoms
10. Activities
20. Return to Community Referral



## When are CAAs Required?

- CAAs are not required for Medicare PPS assessments.
- They are required only for OBRA comprehensive assessments (Admission, Annual, Significant Change in Status, or Significant Correction of a Prior Comprehensive).
- However, when a Medicare PPS assessment is combined with an OBRA comprehensive assessment, the CAAs must be completed in order to meet the requirements of the OBRA comprehensive assessment.





## When Must CAAs Be Completed?

- The Resident Assessment Instrument (RAI) must be completed within 14 days of admission.
- As an integral part of the RAI, CAAs must be completed and documented within the same time frame. It is expected that nursing homes will assess resident needs, plan care and implement interventions in a timely manner.



## Minimum Content of a CAA

- Explain why the CAA triggered.
- Give a description of the MDS triggers.
- Note any risk factors associated with the MDS triggers.
- Explain why a care plan will be developed (what are you trying to do with the care plan?) or why a care plan is not needed.





## How to Know Why the CAA Triggered

- You must know why the CAA triggered.
- Software will just tell you.
- You can refer to the CAA triggering conditions in the RAI manual – Chapter 4.

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>



## Case Study #1: Cognitive Loss/Dementia CAA

- The cognitive loss/dementia CAA focuses on declining or worsening cognitive abilities that threaten personal independence and increase the risk for long-term nursing home placement or impair the potential for return to the community.
- This CAA is triggered when a resident has evidence of cognitive loss.
- See Case Study #1 Handout.







## Case Study #2: Communication CAA

- While many conditions can affect how a person expresses and comprehends information, the communication CAA focuses on the interplay between the person's communication status and his or her cognitive skills for everyday decision making.
- This CAA is triggered when a resident's ability to hear, to express ideas and wants, or to understand verbal content may be impaired.
- See Case Study #2 Handout.



## Case Study #3: Psychosocial Well-Being

- Decreases in a person's social relationships may affect psychological well-being and have an impact on mood, behavior, and physical activity.
- Declines in physical functioning or cognition or a new onset or worsening of pain or other health or mental health issues/conditions may affect both social relationships and mood.
- Psychosocial well-being may also be negatively impacted when a person has significant life changes such as the death of a loved one. Thus, other contributing factors also must be considered as a part of this assessment.
- This CAA is triggered when a resident exhibits minimal interest in social involvement.
- See Case Study #3 Handout.





## Case Study #4: Mood State CAA

- Mood disorders may be expressed by sad mood, feelings of emptiness, anxiety, or uneasiness.
- They may also result in a wide range of bodily complaints and dysfunctions, including weight loss, tearfulness, agitation, aches, and pains.
- Other problems (e.g., lethargy, fatigue, weakness, or apathy) with different causes, which require a very different approach, can be easily confused with depression.
- This CAA is triggered if the Resident Mood Interview, Staff Assessment of Mood, or certain other specific issues indicate a mood issue and/or condition may be present.
- See Case Study #4 Handout.




## Case Study #5: Behavioral Symptoms CAA

- It is essential to assess behavior symptoms carefully and in detail in order to determine whether, and why, behavior is problematic and to identify underlying causes.
- The behavior CAA focuses on potentially problematic behaviors.
- Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and the quality of the lives of those with whom the resident interacts.
- This CAA is triggered when the resident is identified as exhibiting certain troubling behavioral symptoms.
- See Case Study #5 Handout.





## Case Study #6: Activities CAA


- The purpose of the activities CAA is to identify strategies to help residents become more involved in relevant activities, including those that have interested and stimulated them in the past and/or new or modified ones that are consistent with their current functional and cognitive capabilities.
- This CAA is triggered when the resident may have evidence of decreased involvement in social activities.
- See Case Study #6 Handout.



## Case Study #7: Return to Community Referral CAA


- The discharge assessment process requires a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives, with the goal being to assist the individual in maintaining or achieving the highest level of functioning and integration possible.
- This CAA is triggered when a resident expresses interest in returning to the community.
- See Case Study #7 Handout.





## Final Thoughts on CAAs

- 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.
- If you can write a good, descriptive CAA, individualized care planning will be much easier.
- The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (whether or not there is an associated CAA).



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