

4.9 Using the Care Area Assessment (CAA) Resources

Based on the preceding discussions in this Chapter, the following summarizes the steps involved in the CAA process, for those facilities that choose to use the CAA resources in this manual.

Please note: Because MDS 3.0 trigger logic is complex, please refer to the CAT Logic tables within each CAA description (Section 4.10) for detailed information on triggers.

Step 1: Identification of Triggered CAAs. After completing the MDS, identify triggered care areas. Many facilities will use automated systems to trigger CAAs. The resulting set of triggered CAAs generated by the software program should be matched against the trigger definitions to make sure that triggered CAAs have been correctly identified. CMS has developed test files for facility validation of a software program's triggering logic. Generally, software vendors use these test files to test their systems, but the nursing home is responsible for ensuring that the software is triggering correctly.

It is prudent to consider whether or not the software has triggered relevant CAAs for individual residents. For example, did the software miss some CAAs you thought should have been triggered? Do some of the CAAs seem to be missing and are there other CAAs triggered that you did not expect?

For nursing homes that do not use an automated system, the CAT logic will provide the information necessary to manually identify triggered CAAs. The CAT logic is found within the CAT logic tables of each care area's description in section 4.10. These tables provide the MDS items that trigger the 20 (twenty) care areas. Facilities are not required to use this information or to maintain it in the resident's clinical record. Rather, the information is a resource that may be used by the IDT members to determine which CAAs are triggered from a completed MDS.

To identify the triggered CAAs manually using the CAT logic tables in section 4.10:

1. Compare the completed MDS with the CAT logic tables to determine which CAAs have been triggered for review.
2. The CAT logic table will list the MDS item numbers and specific codes that will trigger the particular CAA. To identify a triggered CAA, match the resident's MDS item responses with the MDS item number(s) and code(s) for each care area as listed in the CAT logic tables within section 4.10. If a particular item response matches a code in the CAT logic table for a particular care area, read through the logic statement and qualifiers (i.e., 'IF', 'AND', and 'OR') for that particular care area to determine if that care area is triggered. This means that further assessment using the CAA process is required for that particular care area.
3. Note which CAAs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.
4. Continue through the CAT logic tables for each of the 20 (twenty) care areas matching recorded MDS item responses with trigger indicators until all triggered CAAs have been identified.
5. When the CAT logic review is completed, document on the CAA Summary which CAAs were triggered by checking the boxes in the column titled "Care Area Triggered."

Step 2: Analysis of Triggered CAAs. Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions. While reviewing the CAA, consider what MDS items caused the CAA to be triggered. This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in MDS data. Review of CAAs helps

staff to decide if care plan intervention is necessary, and what types of intervention may be appropriate.

Using the results of the assessment can help the interdisciplinary team (IDT) and the resident and/or resident's representative to identify areas of concern that:

- Warrant intervention;
- Affect the resident's capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident's condition and choices and preferences for interventions;
- Can help to minimize the onset or progression of impairments and disabilities; and
- Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).

Use the information gathered thus far to make a clear issue or problem statement. An issue or problem is different from a finding (e.g., a single piece of information from the MDS or a test result). The chief complaint (e.g., the resident has a headache, is vomiting, or is not participating in activities) is not the same thing as an issue or problem statement that clearly identifies the situation. Trying to care plan a chief complaint may lead to inappropriate, irrelevant, or problematic interventions.

Example:

Chief Complaint: New onset of falls

Problem Statement: Resident currently falling 2-3 times per week. Falls are preceded by lightheadedness. Most falls occurred after they stood up and started walking; a few falls occurred while attempting to stand up from a sitting or lying position.

It is clear that the problem statement reflects assessment findings from which the investigation may continue and relevant conclusions drawn.

While the CAAs can help the IDT identify conditions or findings that could potentially be a problem or risk for the resident, additional thought is needed to define these issues and determine whether and to what extent the care area issue and/or condition is a problem or issue needing an intervention (assessment, testing, treatment, etc.) or simply a minor or inconsequential finding that does not need additional care planning. For example, a resident may exhibit sadness without being depressed or may appear to be underweight despite having a stable nutritional status consistent with their past history. The IDT should identify and document the functional and behavioral implications of identified problematic issues/conditions, limitations, improvement possibilities, and so forth (e.g., how the condition is a problem for the resident; how the condition limits or impairs the resident's ability to complete activities of daily living; or how the condition affects the resident's well-being in some way).

Identify links among triggers and their causes. CMS does not require that each care area triggered be care planned separately. The IDT may find during their discussions that several problematic issues and/or conditions have a related cause, or they might identify that those issues and/or conditions stand alone and are unrelated. Goals and approaches for each problematic issue

and/or condition may overlap, and consequently the IDT may decide to address the problematic issues and/or conditions collectively in the care plan.

For example, behavior, mood, cognition, communication, and psychosocial well-being typically have common risk factors and common or closely related causes of related impairments. Thus, the following CATs naturally coexist and could be combined, assessed through the CAA process, and care planned together as a starting point for any resident: Delirium (CAA #1), Cognitive Loss/Dementia (CAA #2), Communication (CAA #4), Psychosocial Well-Being (CAA #7), Mood State (CAA #8) Behavioral Symptoms (CAA #9), and Psychotropic Drug Use (CAA #17).

Usually, illnesses and impairments happen in sequence (i.e., one thing leads to another, which leads to another, and so on). The symptom or trigger often represents only the most recent or most apparent finding in a series of complications or related impairments. Thus, a detailed history is often essential to identifying causes and selecting the most beneficial interventions, e.g., the sequence over time of how the resident developed incontinence, pain, or anorexia. While the MDS presents diverse information about residents, and the CAAs cover various implications and complications, neither one is designed to give a detailed or chronological medical, psychosocial, or personal history. For example, knowing that the Behavioral Symptoms CAA (#9) is triggered and that the resident also has a diagnosis of UTI is not enough information to know whether the diagnosis of UTI is old or new, whether there is any link between the behavioral issue and the UTI, and whether there are other conditions such as kidney stones or bladder obstruction that might be causing or predisposing the resident to a UTI.

It is the facility's responsibility to refer to sources as needed to help with clinical problem solving and decision making that is consistent with professional standards of practice. It is often necessary to involve the attending physician to identify specific underlying causes of problems, including multiple causes of a single problem or multiple problems or complications related to one or more underlying causes.

Steps 3 and 4: Decision Making and CAA Documentation. The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, goals, preferences, strengths, and needs. The resident, family, or resident's representative should be an integral part of the team care planning process. A care plan that is based on a thorough assessment, effective clinical decision making, and is compatible with professional standards of practice should support optimal approaches to addressing quality of care and quality of life needs of individual residents.

Key components of the care plan may include, but are not limited to the following:

- Resident goals and preferences
- Measureable objective with established timeframes
- Specific interventions, including those that address common causes of multiple issues
- Additional follow-up and clarification
- Items needing additional assessment, testing, and review with the practitioner
- Items that may require additional monitoring but do not require other interventions

- The resident's preference and potential for future discharge and discharge plan

Staff who have participated in the assessment and who have provided pertinent information about the resident's status for triggered care areas should be a part of the IDT that develops the resident's care plan. In order to provide continuity of care for the resident and good communication with all persons involved in the resident's care, information from the assessment that led the team to their care planning decision should be clearly documented. **See Table 2. Clinical Problem Solving and Decision Making Process Steps and Objectives.**

Documentation related to CAAs should include the items previously discussed in Section 4.5.