4.4 What Does the CAA Process Involve?

Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(d)). The CAA process discussed in this manual refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS. The process focuses on evaluating these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning. Interventions must be individualized and based on applying

effective problem solving and decision making approaches to all of the information available for each resident.

Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident. Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan. The significance and causes of any given trigger may vary for different residents or in different situations for the same resident. Different CATs may have common causes, or various items associated with several CATs may be connected.

CATs provide a "flag" for the 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 associated with the care area condition. 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.

A risk factor increases the chances of having a negative outcome or complication. For example, impaired bed mobility may increase the risk of getting a pressure ulcer/injury. In this example, impaired bed mobility is the risk factor, unrelieved pressure is the effect of the compromised bed mobility, and the potential pressure ulcer is the complication.

A care area issue/condition (e.g., falls) may result from a single underlying cause (e.g., administration of a new medication that causes dizziness) or from a combination of multiple factors (e.g., new medication, resident forgot walker, bed too high or too low, etc.). There can also be a single cause of multiple triggers and impairments. For example, hypothyroidism is an example of a common, potentially reversible medical condition that can have diverse physical, functional, and psychosocial complications. Thus, if a resident has hypothyroidism, it is possible that the MDS might trigger any or several of the following CAAs depending on whether or not the hypothyroidism is controlled, there is an acute exacerbation, etc.: Delirium (#1), Cognitive Loss/Dementia (#2), Visual Function (#3), Communication (#4), ADL Functional/Rehabilitation (#5), Urinary Incontinence (#6), Psychosocial Well-Being (#7), Mood State (#8), Behavior Symptoms (#9), Activities (#10), Falls (#11), Nutritional Status (#12), Dehydration (#14), Psychotropic Medication Use (#17), and Pain (#19). Even if the MDS does not trigger a particular care area, the facility can use the CAA process and resources at any time to further assess the resident.

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 hypothyroidism or other complex or mixed causes of impaired behavior, cognition, and mood.

For example, it is necessary to assess a resident's orientation and recall in order to complete portions of the MDS that relate to cognitive patterns (Section C) and to obtain a resident's weight and identify their food intake in order to complete MDS items related to nutritional status (Section K). A positive finding in Section C may trigger one or several CAAs, including Delirium (#1), Cognitive Loss/Dementia (#2), and ADL Functional/Rehabilitation Potential (#5).

Additional evaluation is then required to identify whether the resident has delirium, dementia, or both; how current symptoms and patterns compare to their usual or previous baseline, whether potentially reversible causes are present, what else might be needed to identify underlying causes (including medical diagnoses and history), and what symptomatic and cause-specific interventions are appropriate for the resident. If the Nutritional Status (#12) CAA also triggered, due to weight loss and the resident being found to have delirium, then it is possible that both findings could have a common cause (e.g., an infection or medication side effects), that delirium resulted in impaired nutritional status, or that impaired nutritional status led to delirium, or still other possibilities. Thus, identifying the sequence of events is essential to understanding causes and choosing appropriate interventions.

The RAI is not intended to provide diagnostic advice, nor is it intended to specify which triggered areas may be related to one another or and how those problems relate to underlying causes. It is up to the IDT, including the resident's physician, to determine these connections and underlying causes as they assess the triggered care areas and any other areas pertinent to the individual resident.

Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and can suggest possible approaches to improve a resident's functioning or minimize decline. For example, Section F identifies the resident's preferences for customary routine and activities and Section Q captures information about the resident's desire to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community. These and other MDS items can help focus the assessment and care plan on what is most important to the resident and areas with the greatest potential for functional improvement.

In addition to identifying causes and risk factors that contribute to the resident's care area issues or conditions, the CAA process may help the IDT:

- Identify and address associated causes and effects;
- Determine whether and how multiple triggered conditions are related;
- Identify a need to obtain additional medical, functional, psychosocial, financial, or other information about a resident's condition that may be obtained from sources such as the resident, the resident's family or other responsible party, the attending physician, direct care staff, rehabilitative staff, or that requires laboratory and diagnostic tests;
- Identify whether and how a triggered condition actually affects the resident's function and quality of life, or whether the resident is at particular risk of developing the conditions;
- Review the resident's situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and interventions;
- Determine whether a resident could potentially benefit from rehabilitative interventions;
- Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and psychosocial needs as identified through the comprehensive assessment.