CHAPTER 3
CAAs, CATs, and Care Planning
# Table of Contents

About the Authors and Expert Reviewers ................................................................. v  
AANAC and the Education/Certification Programs. ............................................... vii  
Welcome .................................................................................................................. 1  
Course Objectives ..................................................................................................... 2  
Pretest. ....................................................................................................................... 3  
Glossary ..................................................................................................................... 5  
Common Acronyms. ................................................................................................. 12  
History, Background, and Development of the MDS ............................................. 15  
  Introduction to OBRA ............................................................................................. 15  
  Evolution of the Application of the MDS ............................................................... 16  
  Comprehensive Assessment: The RAI Process ...................................................... 17  
  The Minimum Data Set (MDS) .............................................................................. 20  
  Components of the MDS 3.0 ................................................................................. 20  
  The MDS 3.0 Nursing Home Comprehensive Item Set ......................................... 22  
  Protecting the Privacy of MDS Data ..................................................................... 23  
  Quiz 1: RAI History and Process .......................................................................... 24  
Key RAI Concepts. .................................................................................................... 25  
  The Assessment Reference Date (ARD) ............................................................... 25  
  Types and Timing of Assessments ....................................................................... 26  
  Assessments for SNF PPS ..................................................................................... 31  
  Scheduled Assessments ........................................................................................ 31  
  Unscheduled Assessments .................................................................................. 32  
  Combining Assessments ...................................................................................... 33  
  Signatures on the MDS ........................................................................................ 34  
  Quiz 2: OBRA/SNF PPS ....................................................................................... 35  
Care Area Assessments (CAAs) ............................................................................. 36  
  Care Area Triggers (CATs) ................................................................................... 36  
  Care Planning ........................................................................................................ 38  
  Comprehensive Assessments/Care Plans .............................................................. 39  
  When the RAI Is Not Enough .............................................................................. 39  
  Quiz 3: The CAA Process and Care Planning ....................................................... 42  
Data Collection .......................................................................................................... 43  
  Interdisciplinary Input ........................................................................................... 43  
  Input From All Available Sources ....................................................................... 43  
  Resident Interview ................................................................................................ 44  
  Conducting the Resident Interview .................................................................... 44  
  MDS Accuracy ........................................................................................................ 46  
  Accurate MDS Coding .......................................................................................... 47  
  Documentation to Support the MDS ................................................................... 47  
  Quiz 4: Data Collection and MDS Accuracy ....................................................... 48
About the Authors

Ingrid Johnson Serio, RN, BSN, MPP

Ingrid has over 25 years’ experience in nursing and managed care. She is the past director of content management at AANAC. As such, she contributed to content development, implementation, and quality assurance for member benefits and products across programs. She also served as an expert in long-term care nursing, leadership and management, regulation and policy interpretation, nursing home administration, and other content needs of AANAC. She is active in the Colorado LANE program and the Long-Term Post Acute Care health information technology collaborative. Ingrid has provided expert testimony to the U.S. Congress on management of head injury in the insurance industry and served as a past president of the Illinois chapter of the Case Management Society of America. She also worked with the University of Denver and the Concord Coalition on national fiscal policy education and reform. Ingrid has a bachelor of science in nursing degree from DePauw University and a master of public policy degree from the University of Denver.

Rena R. Shephard, MHA, RN, RAC-MT, C-NE

Rena is the president of RRS Healthcare Consulting Services, providing LTC consulting and training services to facilities, corporations, and attorneys nationwide. She is AANAC’s founding chair and former executive editor and currently serves on the Master Teacher Editorial Advisory Board. She is a sought-out trainer for AANAC’s Resident Assessment Coordinator–Certified (RAC-CT) workshops, is a frequent presenter at AANAC national conferences, and has authored or coauthored 26 of AANAC’s educational courses on MDS coding and nursing leadership. Nationally, Rena is a highly recognized expert in the RAI process and serves as a consultant to several of the CMS MDS-related projects, including MDS 3.0 development, and to California’s Quality Improvement Organization. She served as a DON in skilled nursing facilities for 14 years and has expertise in all aspects of long-term care.
About the Expert Reviewers

Diane Carter, RN, MSN, CS, RAC-CT, C-NE
Diane is president and CEO of AANAC. Active in helping develop the MDS 3.0, she has served on the technical expert panel. She also currently serves on the Advancing Excellence campaign steering committee, the Sioux Falls Group, and the Board of Directors of the Colorado Culture Change Coalition, and is a member of the GeroCoalition through the Hartford Institute with New York University. Prior to forming AANAC, Diane was the associate director of the Colorado Association of Homes and Services for the Aging. She also worked for the Colorado Department of Public Health and Environment as the assistant director of the Health Facilities Division. She was the MDS coordinator for the State of Colorado, a CMS instructor and advisor on Quality Indicators, and manager of the Colorado beta test for implementation of MDS automation. She has been a provider trainer since 1990, when she worked for the Colorado Health Care Association. She has taught more than 400 programs in Colorado and nationally on a variety of regulatory issues including the MDS and its uses in resident assessment, reimbursement, and regulation.

Betty MacLaughlin Frandsen, RN, NHA, MHA, CDONA/LTC, C-NE
Betty has over 30 years of experience in long-term care. She has served as an expert reviewer for numerous AANAC courses, is an author of many of AANAC’s nursing leadership courses (C-NE), is a frequent author for long-term care publications, is a past vice president of education and regulatory affairs for AANAC, and currently serves as AANAC’s curriculum development specialist. She held the position of director of nursing for 14 years, and is a licensed nursing home administrator in Pennsylvania and New York. Betty is past president of NADONA/LTC and was their legislative coordinator in Washington, DC, for 5 years. She was a founding member of the Pennsylvania Culture Change Coalition, served on its board of directors, and was a culture change consultant to nursing homes in New York, Pennsylvania, and Massachusetts.

Judi Kulus, NHA, RN, MAT, RAC-MT, C-NE
Judi has been a certified Master Teacher for the RAC-CT (for MDS certification) since 2004. She began working as a nursing home administrator in 1987. She has a master’s degree in education and has been a registered nurse for 13 years. For the past 25 years, she has focused much of her work on supporting facilities in managing the RAI process, MDS coding, and nursing system quality improvement. She has served as an operations manager, case mix and quality assurance consultant, and crisis control administrator, for a variety of organizations, including facilities in multiple states. She has served as an expert reviewer for numerous other AANAC courses in addition to this one. She currently serves as the vice president of curriculum development for AANAC.
Rebecca LaBarge, RN, RAC-MT

Becky is a popular Master Teacher for AANAC’s RAC-CT workshops, having taught numerous workshops since 2007. She has presented at AANAC conferences and has served as an expert reviewer for other AANAC courses in addition to this one. She began her nursing career in the acute care setting before moving into nursing informatics and finally into long-term care. Becky has served in a variety of nurse management positions, including nursing supervisor, MDS coordinator, regional and corporate MDS specialist, and she currently serves as director of clinical reimbursement for The Tutera Group.

Andrea Otis-Higgins, RN, RAC-MT

Andrea is the CEO/administrator for a not-for-profit, CARF Person-Centered Care–accredited, Practice Green Health Award-winning skilled nursing care organization. Among her previous positions, Andrea served as a corporate director of clinical services for a Maine-based multi-facility organization, a corporate privacy officer, and a manager of clinical operations for a large multi-state health care provider. As well as expertise in the areas of long-term care clinical operations, accreditation, consultation, and HIPAA, Andrea has extensive experience as a multi-level nursing home administrator. She is certified as a director of nursing administration by NADONA and serves on the advisory board to Southern Maine Community College School of Nursing. Andrea has been a Master Teacher for AANAC since 2005 and a guest lecturer for several other institutions, holds a certificate of graduate study in nursing education, and is currently a Leadership MBA candidate.
American Association of 
Nurse Assessment Coordination (AANAC)

Founded in 1999, AANAC is a nonprofit professional membership organization representing health care professionals in the long-term care field. We support clinicians by providing accurate and timely information on:

- Clinical protocols and standards of practice
- Clinical assessment and care planning using the Resident Assessment Instrument/Minimum Data Set (RAI/MDS 3.0) process, including coding conventions, automation, and transmission requirements of federally mandated instruments with opportunities for basic and advanced RAI/MDS certification as a Resident Assessment Coordinator–Certified (RAC-CT®)
- Reimbursement, including the Resource Utilization Groups (RUG-III and RUG-IV), Skilled Medicare Services, and oversight programs including the Recovery Audit Contractors and Value-Based Purchasing (Pay for Performance)
- Quality Assessment and Assurance programs including Quality Measures, the Five-Star Program, and Risk Management
- Survey, enforcement, and compliance strategies, including the Quality Indicator Survey (QIS)
- Leadership development and management, including human resources information, preparing staff for success, and retaining high-performing staff, in addition to certification as a nurse leader (C-NE)
- Research, advocacy, and a strong voice for clinicians in policy and the legislative arena
- With the complexities of federal/state regulations and consumer needs, clinicians must consistently find effective ways to manage the quality of care and life of residents in nursing facilities. We are committed to providing nurses and other professionals with the tools necessary to accomplish this goal.
Pretest

1. Select the statement that is true regarding the assessment period:
   - a. The assessment reference date (ARD) represents the end of the assessment period.
   - b. Care Area Assessment (CAA) information is collected from the period of time following the assessment period.
   - c. The Minimum Data Set (MDS) must be signed off as complete by the end of the assessment period.
   - d. None of the above.

2. The Omnibus Budget Reconciliation Act of 1987 (OBRA ’87):
   - a. Mandated that nursing homes conduct comprehensive, reproducible functional-status assessments of all residents
   - b. Required facility staff to assist residents to attain or maintain the highest practicable mental and physical functional status
   - c. Revamped the survey process
   - d. All of the above

3. The Minimum Data Set:
   - a. Is a stand-alone assessment that provides detailed information about a resident’s health status
   - b. Is designed to facilitate efforts to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident
   - c. Determines resource utilization and subsequent reimbursement
   - d. b and c

4. The utilization guidelines:
   - a. Are instructions on how, when, and why to use the RAI to meet the assessment requirements of OBRA ’87
   - b. Are implemented only for Medicare Part A reimbursement
   - c. Pertain only to conducting the CAAs
   - d. None of the above

5. Which of the following is *not* derived from the Resident Assessment Instrument (RAI) process?
   - a. Quality Measures
   - b. Resource Utilization Groups
   - c. OBRA ’87
   - d. Care plans
6. The primary purpose of the RAI process is to:
   - a. Collect demographic information about nursing home residents
   - b. Develop an appropriate care plan
   - c. Automate facility operations
   - d. Decrease the need for surveys

7. Significant effects of appropriately conducted RAI assessments include:
   - a. Improved resident outcomes
   - b. Improved interdisciplinary communication
   - c. Increased family involvement in care planning
   - d. All of the above

8. CAAs are required:
   - a. For reimbursement under the Skilled Nursing Facility Prospective Payment System (SNF PPS)
   - b. When the Medicare PPS (NP) item set is used as the Quarterly assessment form in some states
   - c. Anytime a comprehensive assessment is completed
   - d. Each time a Quarterly OBRA-required clinical assessment is completed

9. The assessment reference date (ARD):
   - a. Is the date that represents the starting point in time for the assessment
   - b. Must be set by day seven of the assessment period for all assessment types
   - c. Is the date on which all observation periods end for the particular assessment
   - d. Is the day of admission for each assessment

10. Assuming that technical requirements for coverage are met, Medicare Part A coverage in a SNF may include all of the following except:
    - a. Management and evaluation of the care plan
    - b. Maintenance of ROM exercises
    - c. Teaching and training activities
    - d. Observation and assessment
Care Area Assessments (CAAs)

Care Area Triggers (CATs)

As discussed earlier, the RAI process is made up of three basic components: the MDS, CAAs, and care plan. MDS information constitutes the core of the RAI and screens the resident for possible problems or complications. The CATs are the specific answer options entered on an MDS that serve as flags indicating a need for further investigation into possible areas of concern.

Some triggers indicate areas of resident strengths to build upon, in order to improve a resident's functioning or minimize decline. Others point to possible problems or needs. When the software triggers a care area, the assessor can refer to the CAT Logic Table, which starts on page 17 of chapter 4 of the RAI User’s Manual, for the corresponding care area. The assessor can then determine which MDS item triggered the CAA. The 20 CAAs are listed in the following chart (CMS, 2013, chap. 4, p. 4-3):

| Table 1. Care Area Assessments in the Resident Assessment Instrument, Version 3.0 |
|---------------------------------|---------------------------------|
| 1. Delirium                     | 2. Cognitive Loss/Dementia      |
| 7. Psychosocial Well-Being      | 8. Mood State                   |
| 9. Behavioral Symptoms          | 10. Activities                  |
| 11. Falls                       | 12. Nutritional Status          |
| 15. Dental Care                 | 16. Pressure Ulcer              |
| 17. Psychotropic Medication Use | 18. Physical Restraints         |
| 19. Pain                        | 20. Return to Community Referral |

When a care area is triggered, a thorough assessment of the entire care area—not just the trigger—must be conducted. The purpose of this assessment is to determine whether a problem, need, or strength exists, and if it does, to identify the following:

- The nature of the problem
• Causes of the problem and factors that contribute to it
• What risks are created for the resident because of the problem
• Whether there is a need for referral to other health professionals

Regulations do not require a specific tool for this further assessment of the triggered areas, but whichever assessment tools facility staff choose must be current and evidence based or expert endorsed. Appendix C of the RAI User’s Manual includes a list of CAA resources that meet these requirements. These resources are neither mandated nor endorsed by CMS but are provided solely as a courtesy for nursing home staff to use, should they so choose, in completing the RAI CAA process. Facility staff are not required to select from the resources provided, but, as stated above, they must use either these or similar assessment tools.

Some of the information that has to be collected for any CAA is on the MDS, but most of it is not. Critical thinking is imperative in the completion of this process. It is designed to support the IDT’s thorough assessment of the resident to develop an individualized and measurable care plan that will meet the resident’s medical, functional, mental, and psychosocial needs as identified through the comprehensive assessment.

The RAI (MDS + CAAs) must be completed within 14 days of admission. This is mandated by federal regulations. Documentation of interim care planning and decisions must be completed, even if a full workup cannot be completed in that time frame. IDT members are expected to make initial care plan decisions and not wait until the required care plan completion date. CAAs are not required for SNF PPS stand-alone assessments, but they must be included in all OBRA comprehensive assessments, as discussed earlier.

Written documentation of the CAA findings and decision-making process may appear anywhere in a resident’s record, but it is important that the findings be well documented. The “Location and Date of CAA Information” column on the CAA Summary (section V0200A of the MDS 3.0) must be completed to note where the CAA information and decision-making documentation can be found in the resident’s record. The “Addressed in the Care Plan” column should be checked by the assessor when the CAA process leads to the decision to care-plan the issue. A full and detailed explanation of the CAA process can be found in chapter 4 of the RAI User’s Manual.

CAA Process
Step 1. Identify the Triggered CAAs
1. Compare the completed MDS with the CAT Logic Tables in chapter 4 of CMS’ RAI User’s Manual.
2. The CAT Logic Tables list the MDS item numbers and codes that trigger a specific CAA. To identify a triggered CAA, match the resident’s MDS item responses with the numbers and codes in the CAT logic.
3. Note which CAAs are triggered by particular MDS items.
4. Document on the CAA Summary which CAAs were triggered.
Step 2. Analysis of Triggered CAAs
1. Do an in-depth, resident-specific assessment of triggered conditions.
2. Based on assessment, work with the IDT to decide whether triggered areas warrant intervention. Document decisions and reasoning.
3. Use the information gathered to make a clear issue or problem statement.
4. Identify links among triggers and their causes. CMS does not require that each triggered care area be care-planned separately. Goals and approaches may overlap for several triggered CAAs.

Steps 3 and 4. Decision Making and CAA Documentation
1. Create a care plan that is compatible with professional standards of practice and based on the identified issues and/or conditions, but include the resident’s unique characteristics, strengths, and needs.
2. Involve the resident, family, or resident’s representative in the team care planning process.

Care Planning

Federal regulation at 43 CFR 483.20(b)(1), F272, mandates the comprehensive assessment in nursing facilities using the RAI tool as part of an ongoing process through which residents’ functional capability and health status is identified. Facility staff are expected to use resident observation and communication as the primary source of information when completing the RAI.

- **43 CFR 483.20(k)(1), F279, Comprehensive Care Plan**
  The facility staff must develop a comprehensive care plan for each resident that includes measurable objectives and timetables and describes services to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being.

- **43 CFR 483.20(k)(2)(iii), F280, Care Plan Revision**
  The facility staff must review and revise the plan of care as needed with input of the resident (or representative, as appropriate). Surveyor guidance requires that evidence be apparent that the resident was afforded the right to participate in care planning or consulted about care and treatment changes.

The definitive language used on the subject of survey is strongly indicative of the importance of including resident choice in all care planning activities. The direction provided clearly suggests that facilities will be tagged during survey if resident choice is omitted.
Comprehensive Assessments/Care Plans

The *State Operations Manual* requires in F272 that in each facility, staff make a comprehensive assessment of the resident’s needs, using the RAI specified by the state. Each assessment must include:

(i) Identification and demographic information  
(ii) Customary routine.  
(iii) Cognitive patterns.  
(iv) Communication.  
(v) Vision.  
(vi) Mood and behavior patterns.  
(vii) Psychological well-being.  
(viii) Physical functioning and structural problems.  
(ix) Continence.  
(x) Disease diagnosis and health conditions.  
(xi) Dental and nutritional status.  
(xii) Skin Conditions.  
(xiii) Activity pursuit.  
(xiv) Medications.  
(xv) Special treatments and procedures.  
(xvi) Discharge potential.  
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).  
(xviii) Documentation of participation in assessment.  

*(State Operations Manual [SOM], 2011, F272 §483.20[b])*

When the RAI Is Not Enough

For a care plan to be complete and effective, the entire resident must be assessed using a holistic approach, which recognizes the interrelationships of all aspects of the individual’s physical, mental, and psychosocial well-being. The impacts of these on the resident’s overall condition must be identified.

According to the Centers for Disease Control and Prevention (CDC), 18 million courses of antibiotics are prescribed for the common cold in the United States per year. Research shows that colds are caused by viruses. 50 million courses of antibiotics are unnecessarily prescribed for viral respiratory infections.  

*A comprehensive assessment with the input of an engaged interdisciplinary team can help avoid these types of errors.*
The instructions to surveyors under 483.20(b) of the federal regulations make this point clear. They state (SOM, 2011, F272 Intent §483.20[b]):

The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility’s responsibility to assess and address all care needed by the resident.

It is important to be aware that neither the MDS nor CAA process is designed or intended to replace evidence-based, daily clinical assessments in identifying all resident needs or choices. The role of the RAI is to help flag problems. This process will not provide sufficient information to determine whether the findings from the MDS are problematic or merely incidental. The process can be confusing without additional critical thought and investigation. The following five broad areas identified in the RAI User’s Manual are applicable and should be considered for assessment and care planning activities:

**Rehabilitation/Restorative Nursing**
A resident’s potential for physical, occupational, speech, psychological, and other types of rehabilitation needs to be assessed and care-planned. The risk of immobility, for example, should be assessed, and restorative nursing interventions planned accordingly. Complications of immobility, such as damage to the muscular system as indicated by weakness, difficulty walking, posture problems, foot drop, contractures, edema, constipation, calcium depletion, depression, agitation, etc., should be assessed as appropriate. These assessments may include causes, particular risk factors, clinical impressions, and the need for referrals.

**Health Maintenance**
Health maintenance includes monitoring of disease processes that are currently being treated. These include both stable and unstable conditions that need monitoring, such as a history of cardiac problems, hypertension, CHF, pain, dehydration, mental illness, etc. If a resident is taking medications for conditions, regular monitoring of edema, vital signs, blood glucose, etc., may be appropriate.

The IDT may also decide whether or not to list problems on the care plan that no longer affect the resident, are controlled, or need no monitoring. This will depend on the team’s decision about how a given problem affects the resident’s overall functioning or well-being.

Other areas of health maintenance may include terminal care and special treatments such as peritoneal dialysis or ventilator support.

**Discharge Potential**
Discharge potential for each resident needs to be assessed at admission, annually, and as needed. The assessment for discharge potential should focus on what needs to happen before the resident can safely be discharged. If the resident has discharge potential or if discharge is actively being pursued, documentation should appear in the resident’s plan of care.
Medications
The facility must conduct initially and periodically a comprehensive assessment of a resident's needs, including medications (see §483.25[l]). This assessment can be documented anywhere in the resident's record and should include dose, frequency, existing and most likely side effects, relevant lab results, parameter comparisons, and justifications for use. Pharmacists review the drug regimen and discuss irregularities with appropriate facility staff on a monthly basis.

It is the IDT’s decision whether medications need to be addressed in the care plan, based on the outcomes of MDS data. For example, consideration might be given to recent changes in medications, the use of multiple medications, or medications that may put the resident in jeopardy for a decline in functional status. The care plan should alert the staff to medication side effects for which the resident is at particular risk. The IDT may decide to identify a drug(s) as an approach to meeting a goal. Section N of the MDS provides for specific data collection on medication classes. The medication classes documented in the MDS include:

A. Antipsychotic
B. Antianxiety
C. Antidepressant
D. Hypnotic
E. Anticoagulant
F. Antibiotic
G. Diuretic
Z. None of the above were received

It is important to note that no other medications are included in the MDS data, but all medications and the effects of those medications should be well documented and their effectiveness reassessed for use with each resident on an ongoing basis.

Daily Care Needs
In some facilities, all resident daily care needs and standard practice approaches are put on the care plan. Daily care needs that are specific to the resident and are out of the ordinary must be addressed on the care plan. Facility staff must use their professional judgment when making these decisions.

In developing a care plan, the IDT should utilize all available assessment data. In addition to the RAI assessments, other assessments that might be utilized include the admission nursing assessment; other nursing assessments, such as for hydration, intake and output, fall risk, and risk for skin breakdown; the hospital history and physical (H&P); and all ancillary department assessments. Current medications and lab and X-ray reports should also be assessed for indications of problems, complications, and risk factors. In addition, discussion with the resident, family, and other representatives can yield important assessment information.
An in-depth study of care planning is the topic of the AANAC Education Program manual, *Care Planning and the MDS 3.0*.

The table “Clinical Problem Solving and Decision Making Process Steps and Objectives” may be found in the Source Documents section of this manual. Steps in this process include recognition/assessment, problem definition, diagnosis/cause-and-effect analysis, identifying goals and objectives of care, and selecting interventions/planning care.

**Quiz 3: The CAA Process and Care Planning**

1. The CAT logic process:
   - a. Is an expanded study of the item that triggered the CAA as well as surrounding issues
   - b. Provides problem-oriented frameworks for additional assessment
   - c. Is required to be completed within 21 days of admission
   - d. Is simply the statement for each CAA of which MDS item or items trigger it

2. Comprehensive assessments and care plans:
   - a. Are required in all SNF PPS assessments for reimbursement
   - b. Are ignored in the *State Operations Manual* and have no effect on survey outcomes
   - c. Should include input from only the nursing staff and CNAs for full completion
   - d. None of the above