Nationwide Administrative Burden Associated with Removing Section G

Overall Comment

Removal of Section G on OBRA assessments and replacing with Section GG in FY20 provides no time to assess trickle down impacts on resident care assessment and planning (i.e., CAAs), patient quality measures, burdens on providers in case-mix states, and limits options for states to make needed changes.

The Section G to GG changes on OBRA assessments, combined with the implementation of many new or significantly revised MDS items as part of the SPADES implementation (such as the change of PHQ-9 to PHQ 2-9 may also have unintended impacts on the SNF PPS PDPM Payment model case mix determination, in addition to also requiring significant new staff training prior to October 1, 2020, .

Recommendations:

- ***Option 1:*** Delay the removal of Section G on OBRA assessments for another year and make steps to account for SPADES implementation (see ***Attachment A***) so that RUG case mix assignment can still be determined from OBRA assessments. AHCA stands ready to assist CMS in anyway with this course of action; or

- ***Option 2:*** Move forward with removal of Section G from OBRA assessments on October 1, 2020 but with commitment from CMS to: a) Release all MDS-RAI data specifications and user manual instructions as quickly as possible (we believe CMS indicated the data specs would be released in March) to ensure adequate time for education and training among providers, state survey and certification staff, and states; b) Ensure timely CMS national provider training on the MDS changes, via in-person and recorded training sessions (i.e. 2-day training courses held in 2019), including a particular focus and perhaps additional focused trainings (similar to the CMS online Section GG trainings in 2019) that focus on the significant CAA changes; and c) Work with AHCA on efforts at mapping the OBRA item set new Section GG and certain revised SPADES to be able to generate RUG case-mix groups to offer an option for Case Mix States to use as an alternative to the burdensome duplicative OSA assessment process. This would entail releasing the results of the 2019 RTI report that evaluated whether Section GG could replace Section G for long-stay residents.

Summary of Key Points:

1. Federal Statutory Considerations Associated with Section GG Change;
2. Problematic Interactions with Quality Measures Which will Negatively Affect IMPACT Act Efforts;
3. Notable Challenges with CMS Training Efforts in Now Under a Year and Resulting Coding Issues for CMS and Providers with a Rapidly Approaching October 1, 2020 Implementation;
4. Negative Impacts on Depression Identification & Probable Undue Concern Created in PDM Payment Policy;
5. Need to Understand How CMS Arrived at the Validity of Section GG for Long-Stay Patients;
6. If Section GG is Implemented for OBRA Assessments, the Lookback Period Must be Standardized at 3-days; and
7. Elimination of Section G on OBRA Assessments Would Create Serious New Burden in the 28 Case Mix States, Not Reduce Burden.

Detailed Discussion

1. ***Federal Statutory Considerations Associated with Section GG Changes.*** Section G0110 is also used in the Care Area Assessment (CAA) process which is a federally mandated process. Items in this section are used to trigger the following CAAs:

    a. ADL Functional/Rehabilitation Potential
    b. Urinary Incontinence and Indwelling Catheter
    c. Pressure Ulcer

    If updated CAA logic is not available to replace the section G0110 items with items from section GG, providers will have an increased burden in attempting to manually determine which CAAs should trigger – a process currently programmed into provider software. Additionally, the process of working through CAAs (as noted on the CAA worksheets) sec G ADLs impacts: Delirium, Cognitive Loss, Communication, ADLs, Psychosocial, Mood, Activities, Falls, Nutrition, Dehydration, Dental, Psychotropic, Restraints, Pain, Return to Community.

    Recommendation: *CMS must provide explicit and clear training on Care Plan development with particular emphasis on Activities of Daily Living – how they will replace self-care and mobility. See* ***Attachment B****.*

2. ***Problematic Interactions with Quality Measures Which Will Negatively Affect IMPACT Act Efforts.*** Section G0110 is also used in the calculation or risk adjuster/covariate/exclusion criteria of several quality measures:

    a. Short Stay quality Measures:
        i. Residents with Pressure Ulcers that are New or Worsened
        ii. Residents who made improvements in function
    b. Long Stay Quality Measures:
        i. Residents whose need for help with ADLs has increased
        ii. Residents whose ability to move independently worsened
        iii. Percent of low-risk who lose control of their bowels or bladder
        iv. Percent high risk with pressure ulcers
    c. Claims based measures:
        i. Short stay residents who were -
        ii. Number of hospitalizations per 1,000 long stay days
        iii. Short stay residents who have had an outpatient ED visit
        iv. Number of outpatient ED visits per 1,000 long stay resident days
        v. Discharge to community

    Providers use these quality measures regularly to monitor quality of care and undertake QAPI activities. If replacement quality measures are not available when the transition in MDS items occurs, provider practice will be disrupted and entities who rely on quality measure data will have inconsistent and misleading data.

    Recommendation: *Release new quality measure data specifications related to the Section G to GG conversion as well as any other measures impacted by the new/revised SPADES items as soon as possible to permit adequate provider training on the changes. Additionally, collect data, on how the transition from of Section G to Section GG may impact provider quality scores so a*

clear explanation of why impacted QMs scores may fluctuate is available when the results are publicly reported.

3. ***Notable Challenges with CMS Training Efforts and Resulting Coding Issues for CMS and Providers with a Rapidly Approaching October 1, 2020 Implementation.*** Replacing Section G with Section GG on OBRA Assessments will also involve a tremendous training effort beyond the Section GG training efforts to date since October 2016. The coding instructions for section GG are very different from those for section G, and documentation tools to collect the data required are very different. Because Section GG is only currently used for Medicare Part A beneficiaries, many facilities have not fully trained all of their direct care staff on the documentation tools. For example, nurses might be completing the documentation for Section GG items while nursing assistants are the primary data source for Section G. If we are going to transition to using section GG for all assessments, significant numbers of nursing assistants will need to be trained.

Recommendation: *CMS should develop (or repurpose previously developed Section GG raining resources used for SNF QRP and PDPM training) that are customized to documenting and coding of the revised OBRA assessments for long-stay residents.*

4. ***Negative Impacts on Depression Identification & Probable Undue Concern Created in PDPM Payment Policy.*** Condensing the PHQ-9 to PHQ-2 for the purpose of implementing SPADES would impact an already identified concern of inadequate depression identification in this industry. D0200A & D0200B (current MDS) would be used as gateway questions and failure to code either of these indicates the other symptoms would not be assessed. D0200C through D0200I have been coded many times on MDS' and resulted in a summary score that warrants action to be taken. Additionally, there is a potential reimbursement impact for PDPM as well as Case Mix states due to depression not being identified with only the PHQ-2.

Recommendation: *Defer implementation of PHQ-2 on SNF PPS assessments until impacts on PDPM case-mix are accounted for.*

5. ***Need to Understand How CMS Arrived at the Validity of Section GG for Long-Stay Patients.*** Creation of a crosswalk from G to GG would appear to be somewhat of a challenge due to GG does not require coding of "support provided". An ADL score was obtained based on Self Performance and Staff Support. The definitions for the actual activities could be cross walked for example: Bed Mobility would entail use of GG0170A, B, C. Toileting would utilize GG0130C and GG0170F. The issue would be the appropriate and comparable awarding of points.

Recommendation: *CMS should release the RTI Section G to GG feasibility report for use with long stay residents and engage in a discussion about the reliability, validity, and efficacy of using Section GG items for Long-Stay residents with both AHCA and AAPACN.*

6. ***If Section GG is Implemented for OBRA Assessments, the Lookback Period Must be Standardized at 3-days***. We are extremely concerned that the proposed use of a 7-day lookback for the Section GG items on OBRA assessments. Since 2016 CMS has been training SNFs that Section GG requires a 3-day lookback period. The creation of a separate 7-day lookback period for OBRA assessments is inappropriate and will create confusion and errors. For example, how will SNFs code Section GG for a combined SNF-PPS and OBRA admission assessment? In this

case, we believe that the combined OBRA admission and SNF PPS 5-day assessment should use the same day 1-3 assessment period. For all other OBRA comprehensive and quarterly assessments, the 3-day ARD-2 days window should be used as the assessment window. Additionally, to our recollection, earlier prior CMS analysis when developing Section GG found no additional value to justify a 7-day lookback period for these items.

Recommendation: *We believe that CMS should apply a three-day lookback period consistently across all assessment types for Section GG items which would decrease burden for documentation and provide for a more consistent and accurate clinical picture across all assessment types.*

7. ***Elimination of Section G on OBRA Assessments Would Create Serious New Burden in the 28 Case Mix States, Not Reduce Burden.*** There are 28 states who use a version of RUGs for the case mix adjustment in their Medicaid program. Section G, and several SPADES items being modified on OBRA assessments are required items in the calculation of RUG scores. Under the proposed changes to the OBRA item sets, section G and the legacy B0100, D0200, D0300, K0510A, K0510B, and O0100A-F, O100H-J, and O100M would remain only in the Optional State Assessment (OSA), which is a standalone item set that cannot be combined with any other assessment. This means that providers in states who use the RUG system in their Medicaid rate calculations will be required to complete two separate assessments, an OBRA assessment and an OSA, each time an assessment is required. In addition, the OBRA assessment items and documentation for the MDS items impacted by the SPADEs will be different than the legacy items retained in the OSA for the exact same clinical domain This is not just a Section G to GG issue. The extra burden for providers in case mix Medicaid states will be far more if the proposed changes are made, than what the reduction in burden will be for providers in non-case mix states. Below we offer impacts at the facility and patient levels:

   Facility Sample numbers:

   1. 246 bed GA Center: one-month's submission 103 assessments (37 Comprehensive & 66 Quarterly). The total amount of assessments for a quarter = 289
   2. 180 bed MS Center: one-month's submission 62 assessments (29 Comprehensive & 33 Quarterly). The total amount of assessments for a quarter = 215

   Patient Case Example of Two Approaches to Assessment

   In most case mix Medicaid MDS reviews, Myers and Stauffer will release a set of documentation requirements based on the OSA which are either more stringent and/or in completely different from the RAI Manual. In example below,

   Thus, if a state uses the OSA would not code as lying flat, under OBRA assessment would code shortness of breath and lying flat . Thus, the facility is put at risk of legal liability. Additionally, states interpretation of the OSA clinical guidelines would vary by state.

   Shortness of Breath: Difficulty in drawing sufficient breath; labored breathing.

   Dyspnea: Difficult or labored respiration.

   Does require:

   - Documentation of the presence of or observation of shortness of breath or trouble breathing when lying flat during the observation period. Documentation of signs and symptoms such as, but not limited to: 1) increased respiratory rate; 2) pursed lip

breathing; 3) a prolonged expiratory phase; 4) audible respirations and gasping for air at rest; 5) interrupted speech pattern (only able to say a few words before taking a breath); and 6) use of shoulder and other accessory muscles to breath, as applicable; or

- Interventions to avoid an actual reoccurrence of shortness of breath while lying flat that are applied at all times or on an as needed basis must include detailed documentation of the intervention(s) daily. The medical record must reflect the initial occurrence within the facility.
- Consistency with physician orders, progress notes, interdisciplinary notes, treatment records and the person-centered care plan.
- The resident should not be placed in distress to assess this condition.
- The focus of the person-centered care plan should address underlying cause(s) that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible.

Does not include:
Potential for Shortness of Breath while lying flat without evidence of an actual occurrence documented.

Recommendation: *If states were able to use the Federal OBRA assessment instead of the non-Federal OSA to determine the RUG case-mix classification, they would also be required to comply with MDS coding and documentation guidance. CMS should work with AHCA on efforts at mapping the OBRA item set new Section GG and certain revised SPADES to be able to generate RUG case-mix groups to offer an option for Case Mix States to use as an alternative to the burdensome duplicative OSA assessment process. This would require the CMS release of the results of the 2019 RTI report that evaluated whether Section GG could replace Section G for long-stay residents.*

Conclusion

In summary, we have identified a number of potential unintended consequences associated with the proposed implementation of several changes to the SNF PPS and OBRA assessments related to the transition of Section G to GG on the OBRA assessments, as well as the implementation of several new and revised items on all Federal assessments associated with the implementation of the SPADES. beginning October 1, 2020. These potentially have impacts on the SNF PPS PDPM payment model case-mix weight determinations for the nursing component, the RUG case-mix payment approach for 28 state Medicaid systems, several SNF QRP measures, and several critical Federally required care area assessment (CAA) areas as part of the care planning process monitored by state survey and certification agencies.

Overall, these add significant burdens and risks to providers in all states, but particularly in the 28 current Medicaid case-mix states. We believe that many of these concerns require further consideration and mitigation strategies to assure the smoothest transition as such changes are implemented. We have suggested specific recommendations for addressing these concerns, including specific areas requiring intensive CMS educational outreach prior to October 1, 2020 if any or all of these draft MDS changes are implemented without revision.

AHCA AMERICAN HEALTH CARE ASSOCIATION NCAL NATIONAL CENTER FOR ASSISTED LIVING

Attachment A

Attachment A

December 20, 2019
A new DRAFT version of the 2020 MDS item sets (v1.18.0) was posted. This version is scheduled to become effective October 1, 2020. Please note that Section G has been removed from all Federal item sets.

January 23, 2020
A new DRAFT version of the MDS 3.0 Item Set Change History for October 2020 (v1.18.0) was posted. This document reflects the changes in the DRAFT version of the 2020 MDS item sets (v1.18.0) posted on December 20, 2019.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation

MDS Item Field	Item Description	Draft Change Impacting Potential for RUG HIPPS Generation Use on OBRA Assessments	Potential Mitigation Approach to Permit RUG HIPPS to Still be Generated from OBRA Assessments
B0100	Comatose	Item would no longer point to the Section G item G0110, Activities of Daily Living (ADL) Assistance but would now point to Section GG item GG0100, Prior Functioning: Everyday Activities.	• Could RUG grouper map to the comparable GG0100 OBRA Assessment Item? • Purpose is to verify presence of coma and would most likely have similar reliability/validity on RUG CMI mapping
D0200 Item Set	PHQ-9 Resident Mood Interview	Item set eliminated from PPS and OBRA Assessments – remains only on OSA. Replaced with PHQ 2-9 item set D0150.	• Could RUG grouper map to the comparable D0150 OBRA Assessment Items? • Purpose is to identify presence of depression and while PHQ 2-9 may not be as sensitive as PHQ-9, it would likely have acceptably similar reliability on RUG CMI mapping
D0300	PHQ-9 Total Severity Score	Item eliminated from PPS and OBRA Assessments – remains only on OSA. Replaced with PHQ 2-9 item D0160.	• Could RUG grouper map to the comparable D0160 OBRA Assessment Item? • Purpose is to identify presence of depression and while PHQ 2-9 may not be as sensitive as PHQ-9, it

			would likely have acceptably similar reliability on RUG CMI mapping
G0110A1, G0110A2, G0110B1, G0110B2, G0110H1, G0110H2, G0110I1, and G0110I2	Activities of Daily Living (ADL) Assistance	Items eliminated from PPS and OBRA Assessments – remain only on OSA. Replaced with items GG0130A, GG0130C, GG0170E, F, and G, and GG0170A, B, and C.	• Could RUG grouper map to the comparable D0160 OBRA Assessment Item? • Purpose is to identify functional mobility and ADL status. While the scales are different at the item level and the GG items for bed mobility and transfers are more specific, mapping the aggregate scores of these four functional categories between Section G and GG would most likely have similar reliability/validity on RUG CMI mapping
K0510A, K0510B	Nutritional Approaches Parenteral/IV feeding, Feeding tube	Items eliminated from PPS and OBRA Assessments – remain only on OSA. Replaced with items K0520A and K0520B.	• Could RUG grouper map to the comparable D0150 OBRA Assessment Items? • Purpose is to identify presence of nutritional approaches and while the new K0520 items have slightly more detail, the column 2 and 3 data would likely have acceptably similar reliability/validity on RUG CMI mapping.
O0100A, O0100B, O0100C, O0100D, O0100E, O0100F, O0100H, O0100I, O0100J, O0100M	Special Treatments, Procedures, and Programs	Items eliminated from PPS and OBRA Assessments – remain only on OSA. Replaced with items O0110A1, O0110B1, O0110C1, O0110D1, O0110E1, O0110F1, O0110H1, O0110I1, O0110J1, O0110M1.	• Could RUG grouper map to the comparable O0110 OBRA Assessment Items? • Purpose is to identify presence of special treatments procedures and programs and while the new O0110 items have slightly more detail, the aggregate summary items identified as listed are identical to the O0100 items should have identical reliability/validity on RUG CMI mapping.

Attachment B

Communication CAT Logic Table

Triggering Conditions (any of the following):

1. Hearing item has a value of 1 through 3 indicating hearing problems on the current assessment as indicated by:

   B0200 >= 1 AND B0200 <= 3

2. Impaired ability to make self understood through verbal and non-verbal expression of ideas/wants as indicated by:

   B0700 >= 1 AND B0700 <= 3

3. Impaired ability to understand others through verbal content as indicated by:

   B0800 >= 1 AND B0800 <= 3

The information gleaned from the assessment should be used to evaluate the characteristics of the problematic issue/condition and the underlying cause(s), the success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies (e.g., the ability to visually follow non-verbal signs and signals), and the willingness and ability of caregivers to ensure effective communication. The assessment should also help to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address any underlying issues/conditions and causes, as well as verbal and nonverbal strategies, in order to help the resident improve quality of life, health, and safety. In the presence of reduced language skills, both caregivers and the resident can strive to expand their nonverbal communication skills, for example, touch, facial expressions, eye contact, hand movements, tone of voice, and posture.

5. ADL Functional/Rehabilitation Potential

The ADL Functional/Rehabilitation CAA addresses the resident's self-sufficiency in performing basic activities of daily living, including dressing, personal hygiene, walking, transferring, toilet use, bed mobility, and eating. Nursing home staff should identify and address, to the extent possible, any issues or conditions that may impair function or impede efforts to improve that function. The resident's potential for improved functioning should also be clarified before rehabilitation is attempted.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident requires assistance to improve performance or to prevent avoidable functional decline.

The information gleaned from the assessment should be used to identify the resident's actual functional deficits and risk factors, as well as to identify any possible contributing and/or risk factors related to the functional issues/conditions. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, improving or maintaining function when possible, and preventing

additional decline when improvement is not possible. An ongoing assessment is critical to identify and address risk factors that can lead to functional decline.

ADL Functional/Rehabilitation Potential CAT Logic Table

Triggering Conditions (any of the following):

1. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for bed mobility was needed as indicated by:

   (G0110A1 >= 1 AND G0110A1 <= 4) AND
   ((C1000 >= 0 AND C1000 <= 2) OR
   (C0500 >= 5 AND C0500 <= 15))

2. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for transfer between surfaces (excluding to/from bath/toilets) was needed as indicated by:

   (G0110B1 >= 1 AND G0110B1 <= 4) AND
   ((C1000 >= 0 AND C1000 <= 2) OR
   (C0500 >= 5 AND C0500 <= 15))

3. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in his/her room was needed as indicated by:

   (G0110C1 >= 1 AND G0110C1 <= 4) AND
   ((C1000 >= 0 AND C1000 <= 2) OR
   (C0500 >= 5 AND C0500 <= 15))

4. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in corridor was needed as indicated by:

   (G0110D1 >= 1 AND G0110D1 <= 4) AND
   ((C1000 >= 0 AND C1000 <= 2) OR
   (C0500 >= 5 AND C0500 <= 15))

5. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for locomotion on unit (including with wheel chair, if applicable) was needed as indicated by:

   (G0110E1 >= 1 AND G0110E1 <= 4) AND
   ((C1000 >= 0 AND C1000 <= 2) OR
   (C0500 >= 5 AND C0500 <= 15))

6. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for locomotion off unit (including with wheel chair, if applicable) was needed as indicated by:

(G0110F1 >= 1 AND G0110F1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

7. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for dressing was needed as indicated by:

(G0110G1 >= 1 AND G0110G1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

8. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for eating was needed as indicated by:

(G0110H1 >= 1 AND G0110H1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

9. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for toilet use was needed as indicated by:

(G0110I1 >= 1 AND G0110I1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

10. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for grooming/personal hygiene was needed as indicated by:

(G0110J1 >= 1 AND G0110J1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

11. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for self-performance bathing (excluding washing of back and hair) has a value of 1 through 4 as indicated by:

(G0120A>= 1 AND G0120A<= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

12. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while balance during transition has a value of 1 or 2 for any item as indicated by:

((G0300A = 1 OR G0300A = 2) OR
(G0300B = 1 OR G0300B = 2) OR
(G0300C = 1 OR G0300C = 2) OR
(G0300D = 1 OR G0300D = 2) OR
(G0300E = 1 OR G0300E = 2)) AND
((C1000 >= 0 AND C1000 <= 2) OR
(C0500 >= 5 AND C0500 <= 15))

13. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while resident believes he/she is capable of increased independence as indicated by:

G0900A = 1 AND
((C1000 >= 0 AND C1000 <= 2) OR
(C0500 >= 5 AND C0500 <= 15))

14. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while direct care staff believe resident is capable of increased independence as indicated by:

G0900B = 1 AND
((C1000 >= 0 AND C1000 <= 2) OR
(C0500 >= 5 AND C0500 <= 15))

6. Urinary Incontinence and Indwelling Catheter

Urinary incontinence is the involuntary loss or leakage of urine or the inability to urinate in a socially acceptable manner. There are several types of urinary incontinence (e.g., functional, overflow, stress, and urge) and the individual resident may experience more than one type at a time (mixed incontinence).

Although aging affects the urinary tract and increases the potential for urinary incontinence, urinary incontinence itself is not a normal part of aging. Urinary incontinence can be a risk factor for various complications, including skin rashes, falls, and social isolation. Often, it is at least partially correctable. Incontinence may affect a resident's psychological well-being and social interactions. Incontinence also may lead to the potentially troubling use of indwelling catheters, which can increase the risk of life threatening infections.

This CAA is triggered if the resident is incontinent of urine or uses a urinary catheter. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Urinary Incontinence and Indwelling Catheter CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for toileting was needed as indicated by:
   (G0110I1 >= 2 AND G0110I1 <= 4)
2. Resident requires a indwelling catheter as indicated by:
   H0100A = 1
3. Resident requires an external catheter as indicated by:
   H0100B = 1
4. Resident requires intermittent catheterization as indicated by:
   H0100D = 1
5. Urinary incontinence has a value of 1 through 3 as indicated by:
   H0300 >= 1 AND H0300 <= 3
6. Resident has moisture associated skin damage as indicated by:
   M1040H = 1

Successful management will depend on accurately identifying the underlying cause(s) of the incontinence or the reason for the indwelling catheter. Some of the causes can be successfully treated to reduce or eliminate incontinence episodes or the reason for catheter use. Even when incontinence cannot be reduced or resolved, effective incontinence management strategies can prevent complications related to incontinence. Because of the risk of substantial complications with the use of indwelling urinary catheters, they should be used for appropriate indications and when no other viable options exist. The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter, the potential for removal of the catheter, and consideration of complications resulting from the use of an indwelling catheter (e.g., urethral erosion, pain, discomfort, and bleeding). The next step is to develop an individualized care plan based directly on these conclusions.

7. Psychosocial Well-Being

Involvement in social relationships is a vital aspect of life, with most adults having meaningful relationships with family, friends, and neighbors. When these relationships are challenged, it can cloud other aspects of life. Decreases in a person's social relationships may affect psychological well-being and have an impact on mood, behavior, and physical activity. Similarly, 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.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident exhibits minimal interest in social involvement.

Activities CAT Logic Table

Triggering Conditions (any of the following):

1. Resident has little interest or pleasure in doing things as indicated by:

   D0200A1 = 1

2. Staff assessment of resident mood suggests resident states little interest or pleasure in doing things as indicated by:

   D0500A1 = 1

3. Any 6 items for interview for activity preferences has the value of 4 (not important at all) or 5 (important, but cannot do or no choice) as indicated by:

   Any 6 of F0500A through F0500H = 4 or 5

4. Any 6 items for staff assessment of activity preference item L through T are not checked as indicated by:

   Any 6 of F0800L through F0800T = 0

The information gleaned from the assessment should be used to identify residents who have either withdrawn from recreational activities or who are uneasy entering into activities and social relationships, to identify the resident's interests, and to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The care plan should focus on addressing the underlying cause(s) of activity limitations and the development or inclusion of activity programs tailored to the resident's interests and to his or her cognitive, physical/functional, and social abilities and improve quality of life.

11. Falls

A "fall" refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the elderly, including nursing home residents. Falls may indicate functional decline and/or the development of other serious conditions, such as delirium, adverse medication reactions, dehydration, and infections. A potential fall is an episode in which a resident lost his/her balance and would have fallen without staff intervention.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has had recent history of falls and balance problems.

Falls CAT Logic Table

Triggering Conditions (any of the following):

1. Wandering occurs as indicated by a value of 1 through 3 as follows:

   E0900 >= 1 AND E0900 <= 3

2. Balance problems during transition indicated by a value of 1 or 2 for any item as follows:

   (G0300A = 1 OR G0300A = 2) OR

   (G0300B = 1 OR G0300B = 2) OR

   (G0300C = 1 OR G0300C = 2) OR

   (G0300D = 1 OR G0300D = 2) OR

   (G0300E = 1 OR G0300E = 2)

3. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last month prior to admission as indicated by:

   If A0310A = 01 AND J1700A = 1

4. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last 2 to 6 months prior to admission as indicated by:

   If A0310A = 01 AND J1700B = 1

5. Resident has fallen at least one time since admission or the prior assessment as indicated by:

   J1800 = 1

6. Resident received antianxiety medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410B>= 1 AND N0410B<=7

7. Resident received antidepressant medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410C> = 1 AND N0410C<=7

8. Trunk restraint used in bed as indicated by a value of 1 or 2 as follows:

   P0100B = 1 OR P0100B = 2

9. Trunk restraint used in chair or out of bed as indicated by a value of 1 or 2 as follows:

   P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's fall(s), as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop an individualized care plan based

directly on these conclusions. The focus of the care plan should be to address the underlying cause(s) of the resident's fall(s), as well as the factors that place him or her at risk for falling.

12. Nutritional Status

Undernutrition is not a response to normal aging, but it can arise from many diverse causes, often acting together. It may cause or reflect acute or chronic illness, and it represents a risk factor for subsequent decline.

The Nutritional Status CAA process reflects the need for an in-depth analysis of residents with impaired nutrition and those who are at nutritional risk. This CAA triggers when a resident has or is at risk for a nutrition issue/condition. Some residents who are triggered for follow-up will already be significantly underweight and thus undernourished, while other residents will be at risk of undernutrition. This CAA may also trigger based on loss of appetite with little or no accompanying weight loss and despite the absence of obvious, outward signs of impaired nutrition.

Nutritional Status CAT Logic Table

Triggering Conditions (any of the following):

1. Dehydration is selected as a problem health condition as indicated by:

   J1550C = 1

2. Body mass index (BMI) is too low or too high as indicated by:

   BMI < 18.5000 OR BMI > 24.9000

3. Any weight loss as indicated by a value of 1 or 2 as follows:

   K0300 = 1 OR K0300 = 2

4. Any planned or unplanned weight gain as indicated by a value of 1 or 2 as follows:

   K0310 = 1 OR K0310 = 2

5. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

   K0510A1 = 1 OR K0510A2 = 1

6. Mechanically altered diet while a resident is used as nutritional approach as indicated by:

   K0510C2 = 1

7. Therapeutic diet while a resident is used as nutritional approach as indicated by:

   K0510D2 = 1

8. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

   ((M0300B1 > 0 AND M0300B1 <= 9) OR

   (M0300C1 > 0 AND M0300C1 <= 9) OR

16. Pressure Ulcer/*Injury*

A pressure ulcer can be defined as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. They are a common preventable and treatable condition among elderly people with restricted mobility.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Pressure Ulcer/*Injury* CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for bed mobility was needed, or activity did not occur, or activity only occurred once or twice as indicated by:

   (G0110A1 >= 1 AND G0110A1 <= 4) OR

   (G0110A1 = 7 OR G0110A1 = 8)

2. Frequent urinary incontinence as indicated by:

   H0300 = 2 OR H0300 = 3

3. Frequent bowel incontinence as indicated by:

   H0400 = 2 OR H0400 = 3

4. Weight loss in the absence of physician-prescribed regimen as indicated by:

   K0300 = 2

5. Resident at risk for developing pressure ulcers as indicated by:

   M0150 = 1

6. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

   ((M0300B1 > 0 AND M0300B1 <= 9) OR

   (M0300C1 > 0 AND M0300C1 <= 9) OR

   (M0300D1 > 0 AND M0300D1 <= 9) OR

   (M0300E1 > 0 AND M0300E1 <= 9) OR

   (M0300F1 > 0 AND M0300F1 <= 9) OR

   (M0300G1 > 0 AND M0300G1 <= 9))

7. Resident has one or more unhealed pressure ulcer(s) at Stage 1 as indicated by:

   M0300A > 0 AND M0300A <= 9

8. Trunk restraint used in bed has value of 1 or 2 as indicated by:

P0100B = 1 OR P0100B = 2

9. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to draw conclusions about the status of a resident's pressure ulcers(s) and to identify any related causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. If a pressure ulcer is not present, the goal is to prevent them by identifying the resident's risks and implementing preventive measures. If a pressure ulcer is present, the goal is to heal or close it.

17. Psychotropic Medication Use

Any medication, prescription or non-prescription, can have benefits and risks, depending on various factors (e.g., active medical conditions, coexisting medication regimen). However, psychotropic medications, prescribed primarily to affect cognition, mood, or behavior, are among the most frequently prescribed agents for elderly nursing home residents. While these medications can often be beneficial, they can also cause significant complications such as postural hypotension, extrapyramidal symptoms (e.g., akathisia, dystonia, tardive dyskinesia), and acute confusion (delirium).

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

The information gleaned from the assessment should be used to draw conclusions about the appropriateness of the resident's medication, in consultation with the physician and the consultant pharmacist, and to identify any adverse consequences, as well as any related possible causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. Important goals of therapy include maximizing the resident's functional potential and well-being, while minimizing the hazards associated with medication side effects.