# Documentation: Writing Nutrition-Related CAAs

*Megan Finnie, RDN, CSG, LD*
*Chief Operations Officer*
*Dietary Consultants, Inc.*

DRIVING INNOVATION
IN FOODSERVICE MANAGEMENT

## Overview and Learning Objectives

- This session will review Section K of MDS 3.0 and identify how Care Area Assessments (CAAs) relate to care planning. Learn how to effectively write CAAs.
  - **Learning Objectives:**
    1. Define Care Area Assessments (CAAs)
    2. Describe three possible formats for writing nutrition-related CAAs
    3. Describe the role of CAAs in Care Planning
- **1.0 hour CE**

## Table of Contents

Note that all references utilized are cited at the end of the presentation, some are also cited on the slides throughout the presentation.

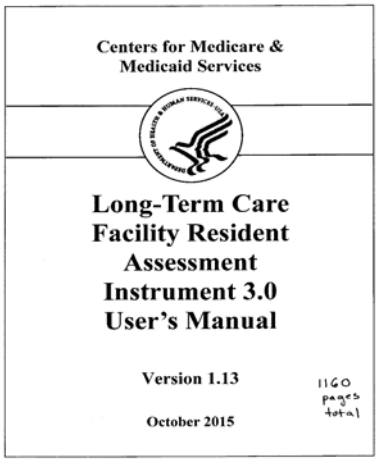




## MDS 3.0- Basics and Quick Review

## MDS 3.0 – Basic and Quick Review

By law, all residents in Medicare and/or Medicaid-certified nursing homes must be assessed according to this prescribed instrument.


Centers for Medicare & Medicaid Services

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual

Version 1.13

October 2015

1160 pages total



## Basics of MDS 3.0 – Let's Review

- See if you can define the following abbreviations:
  - CMS
    Centers for Medicare and Medicaid Services
  - MDS
    Minimum Data Set
  - RAI
    Resident Assessment Instrument (MANUAL)
  - CAT
    Care Area Trigger
  - CAA
    Care Area Assessment
  - ARD
    Assessment Reference Date

## About MDS assessments…

- "MDS assessment forms are completed for all residents in certified nursing homes, regardless of source of payment for the individual resident. MDS assessments are conducted for all nursing home residents within 14 days of admission and at quarterly and yearly intervals, unless there is a significant change in condition. Recognizing their shorter stays, Medicare beneficiaries in a Medicare-covered stay are assessed on or before the 5th, 14th, and 30th day of their stays and every 30 days thereafter."

http://www.nasuad.org/hcbs/article/using-minimum-data-set-mds-facilitate-nursing-home-transition



## About MDS assessments…

- "MDS information is transmitted electronically by nursing homes to their state's MDS database."
- "MDS information from the state's server is captured in the national MDS repository at CMS. The MDS is a part of the Resident Assessment Instrument (RAI) that originates from the nursing home reforms of the late 1980's. It is used by nursing home staff to gather information on a resident's strengths and needs in order to develop an individualized care plan."

http://www.nasuad.org/hcbs/article/using-minimum-data-set-mds-facilitate-nursing-home-transition

## MDS – A BRIEF HISTORY


- OBRA 1987 (Omnibus Budget Reconciliation Act of 1987) – "Mandated that nursing facilities provide necessary care to help each resident attain or maintain the highest practical well-being."
- 1991 - MDS 1.0 implemented
- 1995 - MDS 2.0 Implemented
- 1998 - Medicare PPS and National MDS automation data transmission
- 2002 - Quality Measures publically reported/RAI Manual was revised
- 2010 - MDS 3.0 implemented

https://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/io/mds/mds30traininghandouts.pdf



## MDS 3.0 Data Uses & Applications

WHY DO WE DO THESE MDS 3.0 ASSESSMENTS IN LTC (and for swing beds)?

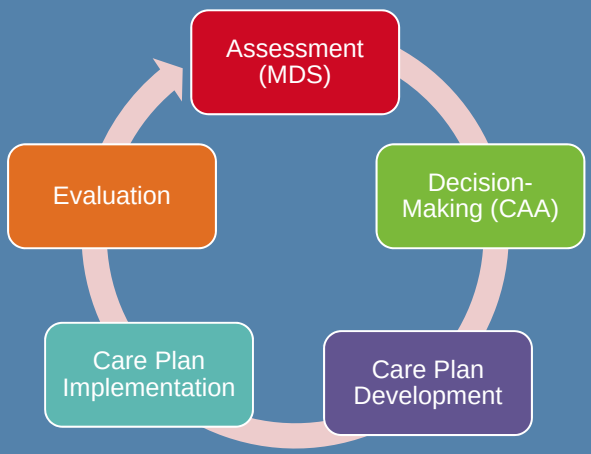
1.) Primary Use: Resident Care Planning
2.) Medicare and Medicaid Payments
3.) Monitoring quality of care, linked to Medicare/Medicaid certification process
4.) Quality Measure information for consumers/the public to see and use

## MDS 3.0 – More than "minimum"

- The MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues that are relevant for a resident.
- Assessments must address more than MDS questions!
  - Federal Regulation: Must maintain 15 months worth of MDS's in resident's active clinical record. Includes all assessments and tracking forms. Can be stored electronic or by hard copy.



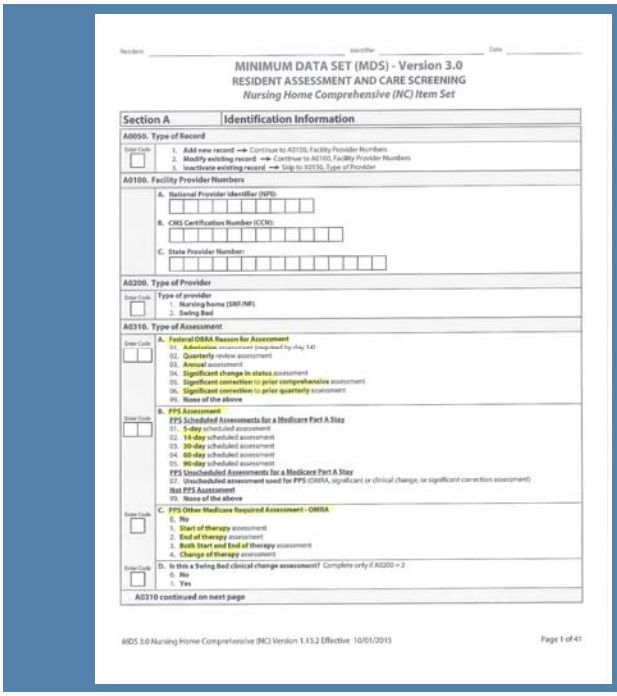
## Overview of MDS, CAAs, and Care Planning




# MDS 3.0 ASSESSMENT TYPES

| | |
|---|---|
| **PPS (Prospective Payment System)** | 5 Day |
| | 14 Day |
| | 30 Day |
| | 60 Day |
| | 90 Day |
| **PPS OMRA (Other Medicare Required Assessment)** | SOT |
| | EOT |
| | COT |
| | Both SOT/EOT |
| **Federal OBRA Comprehensive** | Admission |
| | Annual |
| | Significant Change |
| | *(Significant CORRECTION to a prior comprehensive assessment)* |
| **Federal OBRA Non-Comprehensive** | Quarterly |
| | *(Significant CORRECTION to a prior quarterly assessment)* |
| **Entry/Discharge reporting** | Discharge – return not anticipated |
| | Discharge – return anticipated |
| | Entry (Completed only by MDS Coordinators) |
| | DIF (Completed only by MDS Coordinators) |



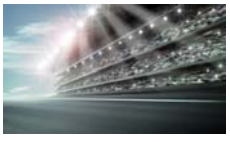


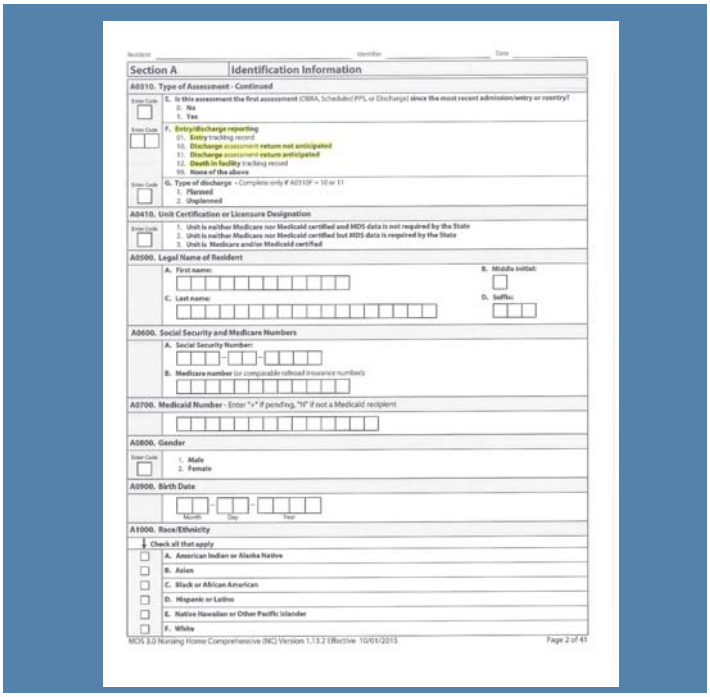
MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
*Nursing Home Comprehensive (NC) Item Set*

| Section A | Identification Information |
|---|---|
| A0050. Type of Record | |
| A0100. Facility Provider Numbers | |
| A0200. Type of Provider | |
| A0310. Type of Assessment | |

A0310 continued on next page

MDS 3.0 Nursing Home Comprehensive (NC) Version 1.13.2 Effective 10/01/2015 Page 1 of 41






| MDS 3.0 Sections | |
|---|---|
| A | Identification Information |
| B | Hearing, Speech, and Vision |
| C | Cognitive Patterns |
| D | Mood |
| E | Behavior |
| F | Preferences for Customary Routine and Activities |
| G | Functional Status |
| H | Bladder and Bowel |
| I | Active Diagnoses |
| J | Health Conditions |
| K | Swallowing/Nutritional Status |
| L | Oral/Dental Status |
| M | Skin Conditions |
| N | Medications |
| O | Special Treatments, Procedures, and Programs |
| P | Restraints |
| Q | Participation in Assessment and Goal Setting |
| R | ---------- |
| S | (Reserved) For additional state-defined items. No Sec. S with Federal MDS 3.0 version |
| T | ---------- |
| U | ---------- |
| V | Care Area Assessment (CAA) Summary |
| W | ---------- |
| X | Correction Request |
| Y | ---------- |
| Z | Assessment Administration (Signatures) |

| MDS SCHEDULE – WEEK OF 6/20/16 | | |
|---|---|---|
| RESIDENT NAME | ASSESSMENT | ARD |
| W. Shakespeare | Q | 6/20/16 |
| A. Einstein | ANNUAL | 6/20/16 |
| I. Newton | ADMISSION | 6/21/16 |
| M. Monroe | 60 DAY/SIG CHANGE | 6/21/16 |
| C. Chaplain | COT | 6/21/16 |
| M. Ghandi | 14 DAY | 6/22/16 |
| A. Hepburn | 5 DAY | 6/23/16 |
| K. Hepburn | 5 DAY/ADMISSION | 6/23/16 |
| G. Washington | 14 DAY/ADMISSION | 6/23/16 |
| P. Revere | DCRA | 6/24/16 |
| J. Kennedy | 5 DAY/QUARTERLY | 6/25/16 |
| A. Lincoln | DCRNA | 6/25/16 |
| T. Jefferson | 90 DAY/Q | 6/26/16 |

**Which assessments will have Sec. V (CAAs)?**

| MDS SCHEDULE – WEEK OF 6/20/16 | | |
|---|---|---|
| RESIDENT NAME | ASSESSMENT | ARD |
| W. Shakespeare | Q | 6/20/16 |
| A. Einstein | **ANNUAL** | 6/20/16 |
| I. Newton | **ADMISSION** | 6/21/16 |
| M. Monroe | 60 DAY/**SIG CHANGE** | 6/21/16 |
| G. Khan | COT | 6/21/16 |
| M. Ghandi | 14 DAY | 6/22/16 |
| A. Hepburn | 5 DAY | 6/23/16 |
| K. Hepburn | 5 DAY/**ADMISSION** | 6/23/16 |
| G. Washington | 14 DAY/**ADMISSION** | 6/23/16 |
| P. Revere | DCRA | 6/24/16 |
| J. Kennedy | 5 DAY/QUARTERLY | 6/25/16 |
| A. Lincoln | DCRNA | 6/25/16 |
| T. Jefferson | 90 DAY/Q | 6/26/16 |

**The COMPREHENSIVE ASSESSMENTS ONLY!**

## MDS 3.0 Assessments

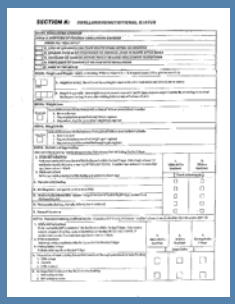
- Remember: Assessments can be combined! (And often are!)
- Section V is for the CAAs (20 CAAs possible)
- CAAs ARE ONLY with Federal OBRA COMPREHENSIVE MDS 3.0 assessments:
  - Admission
  - Annual
  - Significant Change
  - *(Significant CORRECTION to a prior comprehensive assessment)*



## MDS 3.0 ASSESSMENT TYPES

| | |
|---|---|
| **PPS (Prospective Payment System)** | 5 Day |
| | 14 Day |
| | 30 Day |
| | 60 Day |
| | 90 Day |
| **PPS OMRA (Other Medicare Required Assessment)** | SOT |
| | EOT |
| | COT |
| | Both SOT/EOT |
| **Federal OBRA Comprehensive** **ONLY ASSESSMENTS WITH CAAs!!!** | **Admission** |
| | **Annual** |
| | **Significant Change** |
| | *Significant CORRECTION to a prior comprehensive assessment* |
| **Federal OBRA Non-Comprehensive** | Quarterly |
| | *Significant CORRECTION to a prior quarterly assessment* |
| **Entry/Discharge reporting** | Entry |
| | DIF |
| | Discharge – return not anticipated |
| | Discharge – return anticipated |

# MDS 3.0 Section K – Quick Review





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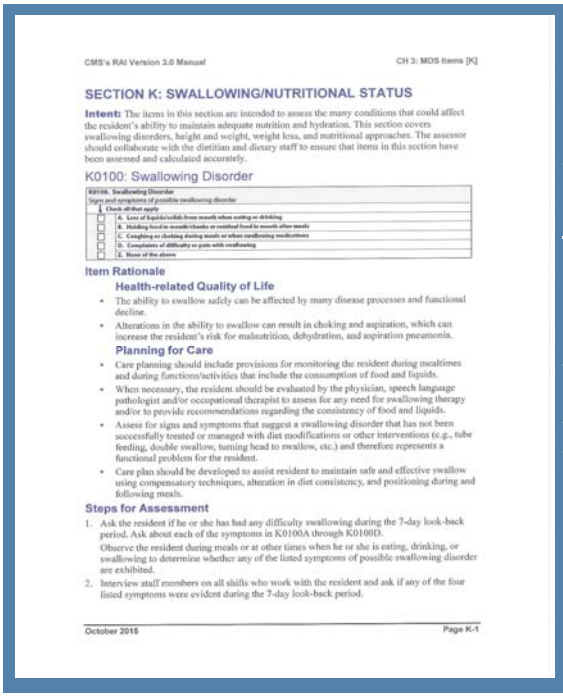
**SECTION K: SWALLOWING/NUTRITIONAL STATUS**

| |
|---|
| **K0100. SWALLOWING DISORDER** |
| **SIGNS & SYMPTOMS OF POSSIBLE SWALLOWING DISORDER** |
| CHECK ALL THAT APPLY |
| ☐ A. LOSS OF LIQUIDS/SOLIDS FROM MOUTH WHEN EATING OR DRINKING |
| ☐ B. HOLDING FOOD IN MOUTH/POCKETING OR RESIDUAL FOOD IN MOUTH AFTER MEALS |
| ☐ C. COUGHING OR CHOKING DURING MEALS OR WHEN SWALLOWING MEDICATIONS |
| ☐ D. COMPLAINTS OF DIFFICULTY OR PAIN WITH SWALLOWING |
| ☐ Z. NONE OF THE ABOVE |
| **K0200. Height and Weight** - While measuring, if the number in X.1 - X.4 round down; X.5 or greater round up |
| ☐☐ inches — A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry |
| ☐☐☐ pounds — B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.) |
| **K0300. Weight Loss** |
| Enter Code ☐ — Loss of 5% or more in the last month or loss of 10% or more in last 6 months<br>0. No or unknown<br>1. Yes, on physician-prescribed weight-loss regimen<br>2. Yes, not on physician-prescribed weight-loss regimen |
| **K0310. Weight Gain** |
| Enter Code ☐ — Gain of 5% or more in the last month or gain of 10% or more in last 6 months<br>0. No or unknown<br>1. Yes, on physician-prescribed weight-gain regimen<br>2. Yes, not on physician-prescribed weight-gain regimen |
| **K0510. Nutritional Approaches** |
| Check all of the following nutritional approaches that were performed during the last 7 days |

| | 1. While NOT a Resident | 2. While a Resident |
|---|---|---|
| 1. While NOT a Resident — Performed while NOT a resident of this facility and within the *last 7 days*. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank<br>2. While a Resident — Performed while a resident of this facility and within the *last 7 days* | ↓ Check all that apply ↓ | |
| A. Parenteral/IV feeding | ☐ | ☐ |
| B. Feeding tube - nasogastric or abdominal (PEG) | ☐ | ☐ |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | ☐ | ☐ |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | ☐ | ☐ |
| Z. None of the above | ☐ | ☐ |

**K0710. Percent Intake by Artificial Route** - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

| | 1. While NOT a Resident | 2. While a Resident | 3. During Entire 7 Days |
|---|---|---|---|
| 1. While NOT a Resident — Performed while NOT a resident of this facility and within the *last 7 days*. Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank<br>2. While a Resident — Performed while a resident of this facility and within the *last 7 days*<br>3. During Entire 7 Days — Performed during the entire *last 7 days* | ↓ Enter Codes ↓ | | |
| A. Proportion of total calories the resident received through parenteral or tube feeding<br>1. 25% or less<br>2. 26-50%<br>3. 51% or more | ☐ | ☐ | ☐ |
| B. Average fluid intake per day by IV or tube feeding<br>1. 500 cc/day or less<br>2. 501 cc/day or more | ☐ | ☐ | ☐ |



CMS's RAI Version 3.0 Manual — CH 3: MDS Items [K]

SECTION K: SWALLOWING/NUTRITIONAL STATUS

**Intent:** The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

K0100: Swallowing Disorder

| K0100. Swallowing Disorder | |
|---|---|
| Signs and symptoms of possible swallowing disorder | |
| Check all that apply | |
| ☐ | A. Loss of liquids/solids from mouth when eating or drinking |
| ☐ | B. Holding food in mouth/cheeks or residual food in mouth after meals |
| ☐ | C. Coughing or choking during meals or when swallowing medications |
| ☐ | D. Complaints of difficulty or pain with swallowing |
| ☐ | Z. None of the above |

Item Rationale

Health-related Quality of Life

- The ability to swallow safely can be affected by many disease processes and functional decline.
- Alterations in the ability to swallow can result in choking and aspiration, which can increase the resident's risk for malnutrition, dehydration, and aspiration pneumonia.

Planning for Care

- Care planning should include provisions for monitoring the resident during mealtimes and during functions/activities that include the consumption of food and liquids.
- When necessary, the resident should be evaluated by the physician, speech language pathologist and/or occupational therapist to assess for any need for swallowing therapy and/or to provide recommendations regarding the consistency of food and liquids.
- Assess for signs and symptoms that suggest a swallowing disorder that has not been successfully treated or managed with diet modifications or other interventions (e.g., tube feeding, double swallow, turning head to swallow, etc.) and therefore represents a functional problem for the resident.
- Care plan should be developed to assist resident to maintain safe and effective swallow using compensatory techniques, alteration in diet consistency, and positioning during and following meals.

Steps for Assessment

1. Ask the resident if he or she has had any difficulty swallowing during the 7-day look-back period. Ask about each of the symptoms in K0100A through K0100D.
   Observe the resident during meals or at other times when he or she is eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorder are exhibited.
2. Interview staff members on all shifts who work with the resident and ask if any of the four listed symptoms were evident during the 7-day look-back period.

October 2015 — Page K-1

Chapter 3, Section K of the RAI Manual is **17 pages** long.

Suggestion: Have a current copy with you at all times in your facilities.

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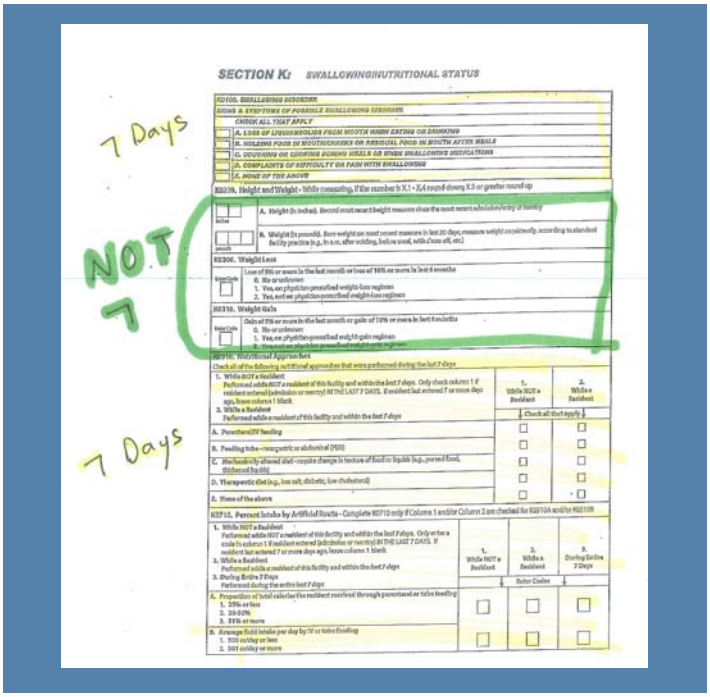
## ARD Review


- ARD = Assessment Reference Date
- For Section K: With the exception of the height, weight, and weight change questions, it's always a 7 day look-back window
- The window is midnight to midnight, ending at midnight on the ARD
- Example: ARD is 6/25/16.
  Look-back time frame is: 6/19/16 to 6/25/16.
  (Midnight on 6/19/16 – midnight on 6/25/16)

| 6/19/16 | 6/20/16 | 6/21/16 | 6/22/16 | 6/23/16 | 6/24/16 | 6/25/16 |
|---|---|---|---|---|---|---|
| Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 (ARD) |

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# Section K
# K0100. Swallowing Disorder

- Only asking about s/s of swallowing difficulty during the 7 day ARD window
- Surprisingly, this question is not a CAT, does not trigger a CAA
- To answer this s/s question: ask the resident, observe the resident, interview staff on all shifts that work with the resident, review all notes/medical records

**SECTION K: SWALLOWING/NUTRITIONAL STATUS**

| K0100. SWALLOWING DISORDER |
|---|
| SIGNS & SYMPTOMS OF POSSIBLE SWALLOWING DISORDER |
| CHECK ALL THAT APPLY |
| ☐ A. LOSS OF LIQUIDS/SOLIDS FROM MOUTH WHEN EATING OR DRINKING |
| ☐ B. HOLDING FOOD IN MOUTH/CHEEKS OR RESIDUAL FOOD IN MOUTH AFTER MEALS |
| ☐ C. COUGHING OR CHOKING DURING MEALS OR WHEN SWALLOWING MEDICATIONS |
| ☐ D. COMPLAINTS OF DIFFICULTY OR PAIN WITH SWALLOWING |
| ☐ Z. NONE OF THE ABOVE |



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## Section K
## K0200. A. HEIGHT & B. WEIGHT

A. Height: Use most current height. Height should always be obtained on admit, and on every readmit. Should be obtained at least annual as well. Height is in inches. Round mathematically.

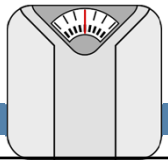
B. Weight: Use the most current weight obtained in the last 30 days. Weight cannot be after ARD. Mathematically round the weight. (If resident cannot be weighed for some well-documented reason, use the standard no-information code (-).)

| K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up | |
|---|---|
| ☐☐ inches | A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry |
| ☐☐☐ pounds | B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.) |



## Section K - K0300. WEIGHT LOSS & K0310. WEIGHT GAIN

- The percentage weight change is based on ROUNDED WEIGHTS!!! Calculate the weight changes from the rounded weights.
- Compares weights at a point closest to 30 and 180 days preceding the current weight. Does not compare any other weights. *(However remember that internally the facility must look at other weight changes and fluctuations, which are to be monitored, assessed, addressed and documented on.)*
- For a new admission, you are still to try to figure out weight history, and can code based on the history if deemed accurate.



## Section K - K0300. WEIGHT LOSS & K0310. WEIGHT GAIN

- Be careful about coding "physician-prescribed" weight loss or weight gain program
- MUST BE AN MD ORDER!
- **Remember: The percent change that is calculated out is NOT rounded!**

| | |
|---|---|
| **K0300. Weight Loss** | |
| Enter Code ☐ | Loss of 5% or more in the last month or loss of 10% or more in last 6 months<br>0. No or unknown<br>1. Yes, on physician-prescribed weight-loss regimen<br>2. Yes, not on physician-prescribed weight-loss regimen |
| **K0310. Weight Gain** | |
| Enter Code ☐ | Gain of 5% or more in the last month or gain of 10% or more in last 6 months<br>0. No or unknown<br>1. Yes, on physician-prescribed weight-gain regimen<br>2. Yes, not on physician-prescribed weight-gain regimen |



## Section K
## K0510. Nutritional Approaches

Only what happened in the 7 day ARD look-back window!

A. Parenteral/IV Feeding – nutrition or hydration through a vein for a nutrition or hydration purpose. Anything received at dialysis does not count. Work with MDS coordinators and RD on this if it occurs in ARD window.

B. Feeding tube – any feeding tube in the 7 days. Work with RD on this. Not coded as mechanically altered, but the formula can be therapeutic.

**K0510. Nutritional Approaches**
Check all of the following nutritional approaches that were performed during the last 7 days

| | 1. While NOT a Resident | 2. While a Resident |
|---|---|---|
| 1. While NOT a Resident: Performed *while NOT a resident* of this facility and within the *last 7 days*. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank<br>2. While a Resident: Performed *while a resident* of this facility and within the *last 7 days* | ↓ Check all that apply ↓ | |
| A. Parenteral/IV feeding | ☐ | ☐ |
| B. Feeding tube - nasogastric or abdominal (PEG) | ☐ | ☐ |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | ☐ | ☐ |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | ☐ | ☐ |
| Z. None of the above | ☐ | ☐ |

# Section K
# K0510. Nutritional Approaches

C. Mechanically Altered Diet – any aspect of diet altered, any thickened liquids

D. Therapeutic Diet – HA! The MOST CONFUSING AND CONTROVERSIAL aspect to Section K. Good luck, everyone seems to disagree. Think *why* the diet is in place, *not what* the diet is. Read this part of section K.

Z. None of the Above

**K0510. Nutritional Approaches**
Check all of the following nutritional approaches that were performed during the last 7 days

| 1. While NOT a Resident Performed *while NOT a resident* of this facility and within the *last 7 days*. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank<br>2. While a Resident Performed *while a resident* of this facility and within the *last 7 days* | 1. While NOT a Resident | 2. While a Resident |
|---|---|---|
| | ↓ Check all that apply ↓ | |
| A. Parenteral/IV feeding | ☐ | ☐ |
| B. Feeding tube - nasogastric or abdominal (PEG) | ☐ | ☐ |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | ☐ | ☐ |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | ☐ | ☐ |
| Z. None of the above | ☐ | ☐ |



# Section K
# K0510. Nutritional Approaches

D. Therapeutic Diet –Think *why* the diet is in place, *not what* the diet is. Read this part of section K.

RAI Manual Exact Definition:
"Therapeutic Diet: A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (ADA, 2011)."

**K0510. Nutritional Approaches**
Check all of the following nutritional approaches that were performed during the last 7 days

| 1. While NOT a Resident Performed *while NOT a resident* of this facility and within the *last 7 days*. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank<br>2. While a Resident Performed *while a resident* of this facility and within the *last 7 days* | 1. While NOT a Resident | 2. While a Resident |
|---|---|---|
| | ↓ Check all that apply ↓ | |
| A. Parenteral/IV feeding | ☐ | ☐ |
| B. Feeding tube - nasogastric or abdominal (PEG) | ☐ | ☐ |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | ☐ | ☐ |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | ☐ | ☐ |
| Z. None of the above | ☐ | ☐ |

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## Section K - Columns 1 and 2 for K0510 and Columns 1,2 and 3 for K0710

Only what happened in the 7 day ARD look-back window!

But it has to be for the whole 7 days. So what if the resident is not in the building the entire 7 days? That's what these columns are for…

NOTE: MDS coordinators usually schedule 5 Day assessments at actual day 7 or 8, so know and understand the ARD concept, look at admission date to see if both of the columns need to be completed.

| K0510. Nutritional Approaches<br>Check all of the following nutritional approaches that were performed during the last 7 days | | |
|---|---|---|
| 1. While NOT a Resident<br>Performed *while NOT a resident* of this facility and within the *last 7 days*. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank<br>2. While a Resident<br>Performed *while a resident* of this facility and within the *last 7 days* | 1. While NOT a Resident<br>↓ Check all that apply ↓ | 2. While a Resident |
| A. Parenteral/IV feeding | ☐ | ☐ |
| B. Feeding tube - nasogastric or abdominal (PEG) | ☐ | ☐ |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | ☐ | ☐ |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | ☐ | ☐ |
| Z. None of the above | ☐ | ☐ |



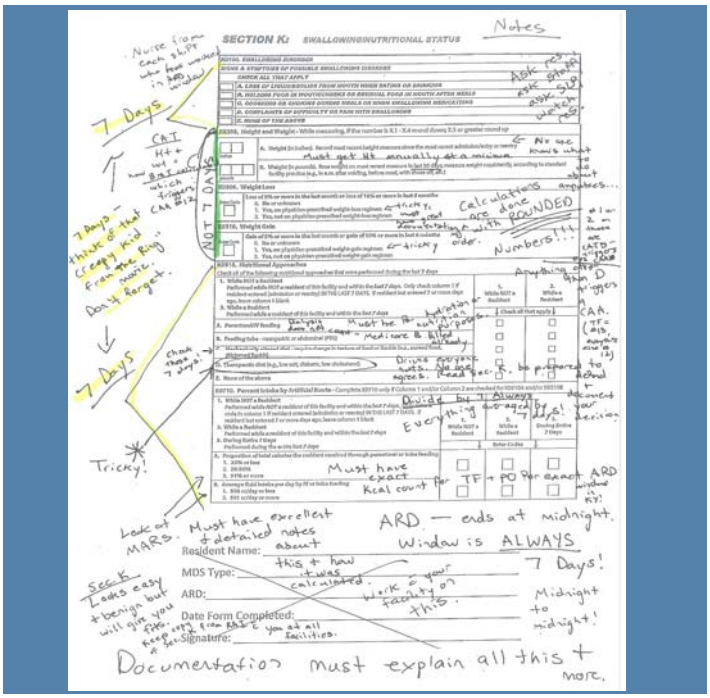
## Section K - K0710. Percent Intake by Artificial Route

This set of two questions is only to be coded if either Parenteral/IV Feeding or Enteral Feeding is coded.

Work with the RD on this section, work with MDS coordinators.

For Calories and Fluid, it is always divided by 7. Even if PN/IV or EN were not received for the entire 7 day ARD look-back window, it is still always divided by 7.

| K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B | | | |
|---|---|---|---|
| 1. While NOT a Resident<br>Performed *while NOT a resident* of this facility and within the *last 7 days*. Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank<br>2. While a Resident<br>Performed *while a resident* of this facility and within the *last 7 days*<br>3. During Entire 7 Days<br>Performed during the entire *last 7 days* | 1. While NOT a Resident<br>↓ Enter Codes | 2. While a Resident | 3. During Entire 7 Days |
| A. Proportion of total calories the resident received through parenteral or tube feeding<br>1. 25% or less<br>2. 26-50%<br>3. 51% or more | ☐ | ☐ | ☐ |
| B. Average fluid intake per day by IV or tube feeding<br>1. 500 cc/day or less<br>2. 501 cc/day or more | ☐ | ☐ | ☐ |

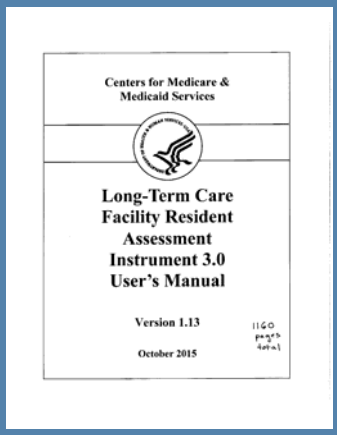



## Quality Measures

- In November 2002, CMS began a national Nursing Home Quality Initiative (NHQI).
- The nursing home quality measures come from resident assessment data (MDS!)
- "These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data have been converted to develop quality measures that give consumers another source of information that shows how well nursing homes are caring for their residents' physical and clinical needs."

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/nursinghomequalityinits/45_nhqimds30trainingmaterials.asp

# Quick mention about Quality Measures…


Centers for Medicare & Medicaid Services

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual

Version 1.13

October 2015

1160 pages total

## MDS 3.0 Data Uses & Applications

WHY DO WE DO THESE MDS 3.0 ASSESSMENTS IN LTC (and for swing beds)?

1.) Primary Use: Resident Care Planning

2.) Medicare and Medicaid Payments

3.) Monitoring quality of care, linked to Medicare/Medicaid certification process

4.) Quality Measure information for consumers/the public to see and use

## Quality Measures

"The current quality measures have been chosen because they can be measured and don't require nursing homes to prepare additional reports. They are valid and reliable. However, they are not benchmarks, thresholds, guidelines, or standards of care. The quality measures are based on care provided to the population of residents in a facility, not to any individual resident, and are not appropriate for use in a litigation action."

"These quality measures were selected because they are important. They show ways in which nursing homes are different from one another. There are things that nursing homes can do to improve their quality measure percentages. The quality measures have been validated and are based on the best research currently available. As this research continues, scientists will keep improving the quality measures on this website."

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/nursinghomequalityinits/45_nhqimds30trainingmaterials.asp



## Quality Measures

- "From the beginning of this initiative, CMS has said that the quality measures are dynamic and will continue to be refined as part of CMS's ongoing commitment to quality. In June 2011, the National Quality Forum (NQF) endorsed our 16 nursing home quality measures. NQF is a voluntary standard setting, consensus-building organization representing providers, consumers, purchasers and researchers. These nursing home quality measures will become the enhanced set of publicly reported quality measures available on Nursing Home Compare in the summer of 2012."

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/nursinghomequalityinits/45_nhqimds30trainingmaterials.asp

## Quality Measures

- Currently 19 Quality Measures
- CASPER Report
- Nursing Home Compare website
- 6 new ones are being added on July 1, 2016, for a total of 25



## Quality Measures

- Only ONE out of the 25 quality measures at this time relates to nutrition (Section K) from the MDS data gathered at each facility
- Residents Who Lose Too Much Weight - Long Stay (Greater than or equal to stay of 101 days in target period.)

# CASPER Report

**CASPER Report**
**MDS 3.0 Facility Level Quality Measure Report**

Page 1 of 1

Facility ID: [redacted]
CCN: [redacted]
Facility Name: [redacted]
City/State: [redacted]
Data was calculated on: 01/06/2014

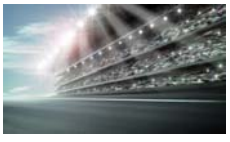
Report Period: 07/01/13 - 12/31/13
Comparison Group: 05/01/13- 10/31/13
Run Date: 01/06/14
Report Version Number: 2.00

Note: Dashes represent a value that could not be computed
Note: S = short stay, L = long stay
Note: I = incomplete; data not available for all days selected
Note: * is an indicator used to identify that the measure is flagged

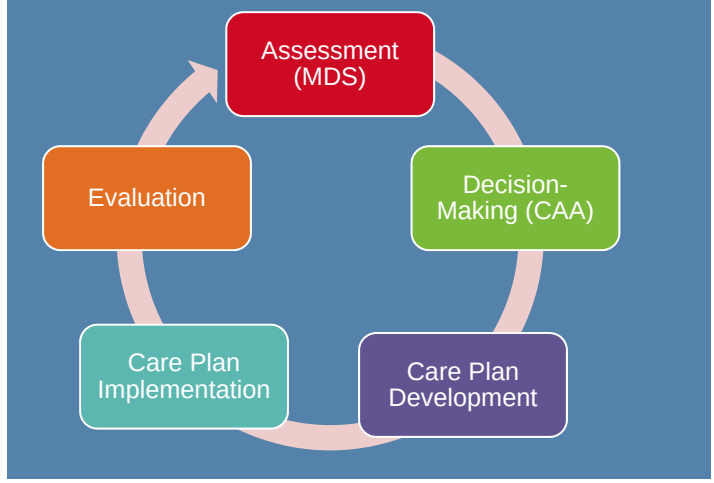
| Measure Description | CMS ID | Data | Num | Denom | Facility Observed Percent | Facility Adjusted Percent | Comparison Group State Average | Comparison Group National Average | Comparison Group National Percentile |
|---|---|---|---|---|---|---|---|---|---|
| SR Severe Pain (S) | N001.01 | | 13 | 40 | 32.5% | 32.5% | 19.1% | 19.5% | 83* |
| SR Severe Pain (L) | N014.01 | | 17 | 65 | 26.2% | 25.4% | 8.1% | 8.6% | 96* |
| Hi tes Ulcer (L) | N015.01 | | 4 | 64 | 6.3% | 6.3% | 6.9% | 6.7% | 54 |
| Ne se Pres Ulcer (S) | N002.01 | | 1 | 45 | 2.2% | 1.8% | 1.1% | 1.2% | 80* |
| Ph traints (L) | N027.01 | | 0 | 111 | 0.0% | 0.0% | 1.7% | 1.4% | 0 |
| Fa | N032.01 | | 64 | 111 | 57.7% | 57.7% | 44.5% | 44.4% | 82* |
| Fa aj Injury (L) | N013.01 | | 5 | 111 | 4.5% | 4.5% | 2.8% | 3.3% | 72 |
| An n Med (S) | N011.01 | | 0 | 25 | 0.0% | 0.0% | 1.9% | 2.8% | 0 |
| An n Med (L) | N031.02 | | 28 | 90 | 31.1% | 31.1% | 13.9% | 20.6% | 85* |
| An ty/Hypnotic (L) | N033.01 | | 5 | 49 | 10.2% | 10.2% | 8.5% | 10.7% | 58 |
| Be affect Others (L) | N034.01 | | 38 | 105 | 36.2% | 36.2% | 22.2% | 24.9% | 79* |
| De Sx (L) | N030.01 | | 0 | 104 | 0.0% | 0.0% | 4.5% | 6.5% | 0 |
| UT | N024.01 | | 6 | 109 | 5.5% | 5.5% | 5.6% | 6.5% | 50 |
| Left Bladder (L) | N026.01 | | 2 | 106 | 1.9% | 2.0% | 4.0% | 3.8% | 32 |
| Lo- Lose B/B Con (L) | N025.01 | | 9 | 26 | 34.6% | 34.6% | 45.4% | 43.7% | 32 |
| Excess Wt Loss (L) | N029.01 | | 11 | 109 | 10.1% | 10.1% | 8.6% | 7.8% | 72 |
| Incr ADL Help (L) | N028.01 | | 23 | 98 | 23.5% | 23.5% | 14.6% | 16.0% | 82* |

# What are CAAs?

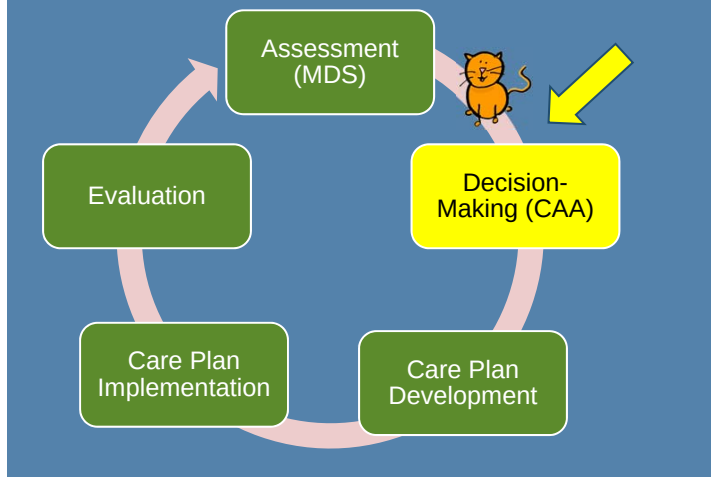
## (What are CATs?)



# Overview of MDS, CAAs, and Care Planning




# Let's talk about CAAs! (and CATs!)




## Let's Talk about CATs first! The CAT triggers the CAA!

- "A care area trigger (CAT) – MDS response indicating that clinical factors exist that may or may not represent a condition that should be care planned"
- "When a resident's status on a particular MDS item matches one of the CATs , then the related care area is triggered for further assessment"
- "Triggers flag conditions that warrant further investigation"

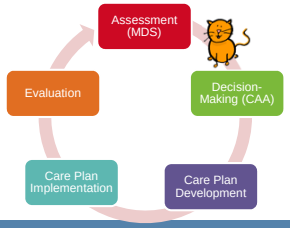


## CAT (Care Area Trigger)

- "A care area may be triggered by:
  - A single MDS response
  - A combination of more that one response options
  - A comparison of residents status on current assessment and prior assessment"

## CAT (Care Area Trigger)

- "Triggered care areas form a critical link between MDS and care planning decisions"
- "CAAs cover the majority of problem areas known to be problematic for nursing home residents"
- "Triggered CAA must be assessed; May or may not warrant being addressed by care plan"






## CAA Definition

- Only with the *Comprehensive* MDS assessments.
- 1.) Admission 2.) Annual 3.) Significant Change

- **"4.3 What Are the Care Area Assessments (CAAs)?**

The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths. Specific "CAT logic" for each care area is identified under section 4.10 (The Twenty Care Areas). The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. Interpreting and addressing the care areas identified by the CATs is the basis of the Care Area Assessment process, and can help provide additional information for the development of an individualized care plan."

## The 20 Care Areas - Section V

1. Delirium
2. Cognitive Loss
3. Visual Function
4. Communication
5. ADLs- Functional Status
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-being
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutrition
13. Feeding Tube(s)
14. Dehydration/Fluid Maintenance
15. Dental Care
16. Pressure Ulcer(s)
17. Psychotropic Medication Use
18. Physical Restraints
19. Pain
20. Return to Community Referral

Now let's review the most relevant ones to dietary/nutrition!



| MDS 3.0 Sections | |
|---|---|
| A | Identification Information |
| B | Hearing, Speech, and Vision |
| C | Cognitive Patterns |
| D | Mood |
| E | Behavior |
| F | Preferences for Customary Routine and Activities |
| G | Functional Status |
| H | Bladder and Bowel |
| I | Active Diagnoses |
| J | Health Conditions |
| K | Swallowing/Nutritional Status |
| L | Oral/Dental Status |
| M | Skin Conditions |
| N | Medications |
| O | Special Treatments, Procedures, and Programs |
| P | Restraints |
| Q | Participation in Assessment and Goal Setting |
| R | ---------- |
| S | (Reserved) For additional state-defined items. No Sec. S with Federal MDS 3.0 version |
| T | ---------- |
| U | ---------- |
| V | Care Area Assessment (CAA) Summary |
| W | ---------- |
| X | Correction Request |
| Y | ---------- |
| Z | Assessment Administration (Signatures) |

## CAA #12 Nutrition

Has 8 CATs

1.) From Section J: Dehydration

2.) From Section K: BMI too high or too low (calculated from height and weight, any number other than "normal" at 18.5-24.99)

3.) From Section K: Any sig weight loss

4.) From Section K: Any sig weight gain

5.) From Section K: Parenteral/IV Fluids

6.) From Section K: Mechanically Altered Diet

7.) From Section K: Therapeutic Diet

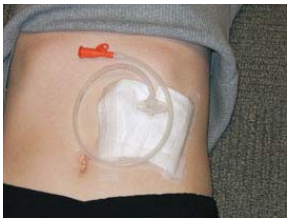
8.) From Section M: Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by selections in section M



## CAA #13 Feeding Tubes

Has only one CAT

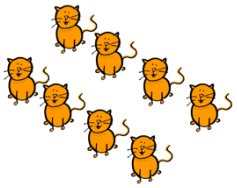
1.) From Section K – K0510B Feeding Tube



## CAA #14 Hydration/Fluid Maintenance

HAS 8 CATs

1.) From Section J: Fever
2.) From Section J: Vomiting
3.) From Section J: Dehydration
4.) From Section J: Internal Bleeding
5.) From Section I or M: Infection Present
6.) From Section H: Constipation Present
7.) From Section K: Parenteral/IV Feeding
8.) From Section K: Feeding Tube





## CAAs

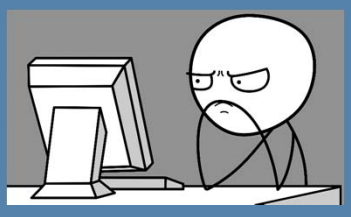
- A CAA is NOT always triggered!
- Sometimes (those lucky few times!) you do NOT have to write a #12, #13, or #14 CAA!

## CAAs

- A CAA in a certain area may NOT always be triggered!
- HOWEVER, not having a CAA for a specific care area DOES NOT necessarily mean that NO CARE PLAN IS NEEDED for that area!
- YOU STILL MIGHT NEED A CARE PLAN FOR THAT CARE AREA!



## CAA DOCUMENTATION



## POP QUIZ! ABOUT CAAs

1.) Which assessments will have CAAs?
Only Federal OBRA COMPREHENSIVE assessments!

2.) Where are the CAAs located in the MDS 3.0 assessment?
Section V

3.) Do the CAAs get transmitted with the MDS 3.0 data to your state's MDS database?
NO

4.) Does anyone ever read the CAAs?
They should…

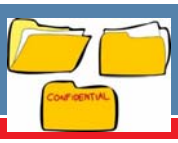


## CAA Documentation

- "Written documentation of the CAA findings and decision-making process may appear anywhere in the resident's record"
- "No particular location or format is required"
- "Section V indicates Location and Date of CAA documentation



## CAA Documentation




Popular formats:

1.) Checklist with summary analysis
2.) CAA review note summarizing and analyzing the findings
3.) No additional note or summary other than routine chart documentation (In Section V it provides location in the chart where information is located.)

CMS:

"In some cases, it may be prudent to write a summary of the CAA information, especially if the assessment documentation in the record is incomplete, unclear, too scattered, or unfocused. It may also be useful to have the information summarized for quick reference by staff."



## CAA Documentation

- CAA documentation is to discuss the nature of the issue or condition. What is the problem for this resident?
- Complications that affect the resident from this problems
- Other risk factors that arise because of the presence of this problem
- Note factors that must be considered in developing the care plan
- Is a referral to other health care providers needed?

## CAA Documentation – Tips for Writing?

Tips:

- Explain all the CATs that actually triggered the CAA. Describe if they are problematic or not, or are a potential to be a problem. Describe what is being done, or what is planned to be done to address any of these identified problems.
- Ideally all CATs would already be addressed completely and thoroughly in the charting. Talk to other disciplines about this. (Talk to your dietitian about their nutrition-related charting for comprehensives!)



## CAA Documentation – Tips for Writing?

Tips:

- Address other “problems” related to eating and nutrition that have been identified, problems that may not be a CAT
- Address the strengths, wishes, desires, plans, routines, habits, and statements made by the resident that revolve around nutritional status and or PO intake.
- Work with your MDS coordinators and IDT, talk to them frequently, review the CAA writing and care planning process with them
- Refer to the RAI Manual

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## CAA Quiz - What we just learned…

True or False…

1.) A CAA must be written out with a checklist and a summary.

False (CMS does NOT mandate a particular format for writing the CAAs.)

2.) If a CAA is triggered, a CAA does not have to be written if the assessment is thorough and complete.

True (A CAA does not have to be written if the documentation in the medical record is sufficient.)



## HOW Do CAAs relate to Care Planning?


## CAAs (Care Area Assessments) lead to ➪ Care Planning

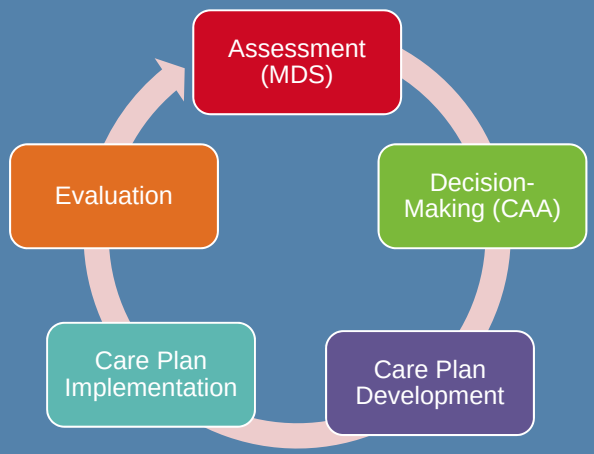
The Care Plan can and should be about more than just the CATs/CAAs, but the CATs/CAAs are the starting point

"The critical link between the MDS 3.0 and care planning results from two key areas:
1.) CATs
2.) CAAs

PERSON-CENTERED CARE PLANS!



## Overview of MDS, CAAs, and Care Planning




**Here's an example of what an Annual assessment might look like. I have highlighted the information that relates back to MDS sec K.**

Annual (Skin): 82 yo female. Diagnoses include: Hx CVA, Dementia, HTN, GERD, Hiatal Hernia, DM Type 2, OA, OP. Current weight – 130 lbs (6/25/12 wt). Weight Changes: 0.8% gain x 1 mo, 5.4% loss x 3 mo, 4.2% loss x 6 mo. No significant weight changes noted. Original admit weight 147.0 lbs on 1/12/11, weight has gradually decreased over time. However, per RD discussion with resident on 4/30/12, resident was pleased with this weight loss. Resident had reported her usual weight during her adult life as being ~105 lbs, and that her weight had climbed to 160 lbs during her 70's. The weight gain had bothered her. Also note that resident receives diuretic meds and has a hx of edema, and this may have influenced weight changes over time. Ht = 60." IBW=100 lbs, IBWR= 90-110 lbs, is at 130% IBW. No amputations noted. Adjusted BW = 108 lbs (49.1 kg). BMI = 25.4 (Overweight.) Resident desires weight loss, current goal weight range – 120-135 lbs x next 3 months, with gradual weight losses of 1-2 lbs per week desired by resident at this time. Current Diet Order: Regular, NAS, CCHO, thin liquids. PO intake 97% of meals x past 7 days, 2156 ml PO fluid avg/day x past 3 days. Supplements: Juven 1 packet PO BID x 30 days, ProStat 101 30 ml PO BID x 30 days. Per review of MAR, 100% intake of Juven and 25% intake of ProStat 101 x past 7 days. Resident receives a therapeutic diet order. The NAS diet is provided r/t hx of edema issues and r/t HTN/hx CVA dx to decrease sodium in the diet to reduce health complications associated with excessive sodium intake. The CCHO diet is provided r/t DM type 2 dx to help promote stable BG levels and also to help promote weight loss/prevent weight gain. The Prostat is also a therapeutic diet intervention to help promote wound healing. Estimated Daily Nutritional Needs: Calories: 1250-1500 kcal/day (~25-30 kcal/kg Adj. BW), Fluid: 1250-1500 mL/day (~25-30 mL/kg Adj. BW), Protein: 59-69 (1.2-1.4 g pro/kg Adj. BW). PES Statement: Overweight R/T hx of excessive caloric intake AEB BMI = 25.4. Meds include: Lasix, Coumadin, Synthroid, Pepcid. Colace. MVI w/ minerals, Vit C 500 mg PO BID x 30 days, Ferrous Sulfate, monthly Vit B12 injections. Feeds self with tray set-up. NKFA. Ambulates with walker x 1 assist or propels self in W/C. Labs 6/15/12: Hgb 11.5 L, Hct 42.3, Glu 108 H, Na 141, K 4.2, BUN 16, Creat 0.6, TP 6.8, Alb 3.2 L. (Note Albumin is not considered an accurate marker of nutritional status.) Skin: Three Stage II ares to Left Heel – all healing per 6/23/12 wound documentation note by nursing. No edema noted per 6/20/12 skin assessment form. Note that MVI, Vit C, Juven and Prostat are all provided at this time to help promote wound healing. Per discussion with nursing staff, no overt S/S of chewing or swallowing problems noted. (No coughing/choking/pocketing/loss of liquids or solids from mouth, complaints of pain or difficulty noted with swallowing.) Resident has own natural teeth, in poor condition, with some missing. Per RD interview with resident on 6/26/12, resident reports being pleased with the food, no new food preferences noted. Resident denies any chewing or swallowing difficulty, denies mouth pain. Resident stated, "I really hate that thick goocy liquid they give me, but they tell me it's to heal up my foot, but I just can't stand that stuff." Rec: 1.) D/C ProStat 101 30 ml PO BID x 30 days. (Rec is r/t resident's frequent refusal of and dislike of ProStat. Note that resident is eating well, weight is appropriate for resident, and multiple other nutritional interventions are in place to promote wound healing.) RD available pm. ————— Janc Doc, RD, LD

**1.) Fill out Section K form from this. Easy to do?**

**2.) What are the CAAs triggered from this, if any?**

**3.) Could you write the CAA from this?**

**4.) Could you create appropriate nutrition-related care plan(s) off of this information?**

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# Questions?

## THANK YOU!

**Megan Finnie, RDN, CSG, LD**
**Email: mfinnie@dietaryconsultants.com**

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