MDS and Care Planning for the Nutritional Professional

Overview of The Resident Assessment Instrument (RAI) Process

The Minimum Data Set (MDS)

- Assessment tool mandated by OBRA 1987 that drives:
  - Resident care
  - Medicare reimbursement
  - Medicaid reimbursement in many states
  - Regulatory oversight and facility quality improvement activities through the Quality Measures (QMs)
  - Consumer oversight through Quality Measures (QMs)
- Broad screening tool to identify potential problem areas that require further assessment before care planning
Accuracy of Assessments

MDS must accurately reflect
- the resident's status
- as of the Assessment Reference Date (ARD)
(42 CFR 483.20(g), F278)

Note that the MDS is a *functional* assessment only

Accuracy of Assessments

- **RAI User’s Manual** is the definitive resource for MDS coding instructions
  - You should always use it when completing MDS items
  - Pay attention to the clarifications, issues of note, and other pertinent information needed to understand how to code each item
  - Ensure you have the most current version
    - CMS updates the manual frequently
    - CMS posts updates on its website
  - Be alert to manual updates even if the manual is embedded in your MDS software

Accuracy of Assessments

- The RAI Process is intended to be an Interdisciplinary Process:
  - The “appropriate, qualified health professional” should correctly document the resident’s status
  - Assessment must be conducted by “staff that are qualified to assess relevant care areas” and knowledgeable about the resident
  - Assessments must be conducted “with the appropriate participation of health professionals”
Data Collection and Coding Decisions

• Collect information
  - From all sources permitted by the instructions, see next slide
  - For the time frame of the look-back period only
    - Look-back is seven days unless rules state otherwise
    - Anything that happened before or after look-back period does not go on the MDS

• Apply the item-specific rules from the RAI User’s Manual to the data collected

Data Collection and Coding Decisions

• Potential Information Sources:
  - Talk to the resident
  - Talk to the family
  - Talk to your staff
  - Review the record
  - Observe yourself

Care Area Assessments (CAAs)

• The MDS is a screening tool that provides clues about the resident’s functional and health status.
• Specific MDS answer options are Care Area Triggers, which indicate that a particular area could be a problem for that resident
• There are 20 Care Areas which can be triggered
• A Care Area Assessment must be completed for each care area that is identified as a possible problem, or “triggered”
Care Area Assessments (CAAs)

- CAAs are required only with comprehensive assessments:
  - Admission assessment (A0310A = 01)
  - Annual assessment (A0310A = 03)
  - Significant Change in Status Assessment (A0310A = 04)
  - Significant Correction to prior Comprehensive Assessment (A0310A = 05)

- CAAs are not required with:
  - Quarterly assessments (A0310A = 02)
  - Significant Correction to Prior Quarterly Assessment (A0310A = 06)
  - Standalone SNF PPS reimbursement assessments (A0310B)

The Care Plan

- The care plan is the working action plan developed from the findings that result from working the triggered CAAs.
- Person-centered, individualized, care plan designed to address the resident’s specific problems, risk factors, needs, goals, preferences, and choices.

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. Nurse assessors should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

K0100: Swallowing Disorder

• Identifies and symptoms that may indicate that swallowing problem exists
• Does not diagnose swallowing problem
• All staff who observe resident throughout the day should provide input; also ask resident
• These items are important for care planning and are also risk adjustment items for the Successful Discharge to the Community Quality Measure

K0100: Swallowing Disorder

• 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
K0200: Height and Weight

• A. Height
  • Measure height on admission and annually
  • If height measurement not taken in last year, measure for this assessment
  • Use **mathematical rounding**
    o Round up to nearest whole number if decimal is \( \geq 0.5 \)
    o Round down if decimal is \(< 0.5\)
  • If unable to stand, measure frame while in bed
  • If unable to measure in bed or if missing limbs, use other means in accordance with facility policy

K0200: Height and Weight

• B. Weight
  • Weight should be **no more than one month old**
    o If weight in chart was taken more than 30 days prior to ARD, weigh again
    o If more than one weight was recorded for the 30 days prior to the ARD, use most current one
  • Use mathematical rounding and enter whole number
  • If unable to weigh due to extreme pain, immobility, risk of pathological fractures, extreme obesity, enter dash (–) and document reason

K0300: Weight Loss

• Weight loss is based on change of **5% or more in last 30 days and 10% or more in last 180 days**
• Compares two snapshots in time. Compare the weight in the current observation period to:
  • The weight taken **closest to 30-days** preceding the current weight
  • The weight taken **closest to 180 days** preceding the current weight
K0300: Weight Loss

• Coding options
  • 0. No or unknown
  • 1. Yes, on physician-prescribed weight-loss regimen
  • 2. Yes, not on physician-prescribed weight-loss regimen

• Physician-prescribed weight-loss regimen
  • With care plan goal of weight reduction; weight loss is intentional
  • May employ calorie-restricted diet or other weight-loss diets and exercise
  • Includes expected weight loss due to loss of fluid with physician orders for diuretics
  • To code K0300 as 1, Yes, the expressed goal of the weight-loss diet or the expected weight loss of edema through the use of diuretics must be ordered and documented by the physician and reflected in the plan of care

K0310: Weight Gain

• Weight gain is based on change of 5% or more in last 30 days and 10% or more in last 180 days
• Compares two snapshots in time. Compare the weight in the current observation period to:
  • The weight taken closest to 30-days preceding the current weight
  • The weight taken closest to 180 days preceding the current weight

K0300: Weight Gain

• Coding options
  • 0. No or unknown
  • 1. Yes, on physician-prescribed weight-gain regimen
  • 2. Yes, not on physician-prescribed weight-gain regimen

• Physician-prescribed weight-gain regimen
  • Weight gain must have been planned and pursuant to a physician’s order
  • Expressed goal of the weight gain diet must be documented
K0510: Nutritional Approaches

- Check column 1 if received prior to A1600 Entry date and within 7-day look-back period
- Check column 2 if received on or after A1600 Entry date and within 7-day look-back period
- In either case, check only if chart reflects a nutrition or hydration need

K0510 Nutritional Approaches

- Include any and all nutrition and hydration received by the nursing home resident in the last seven days regardless of where delivered:
  - At the nursing home or
  - At a hospital as an outpatient or
  - As an inpatient, provided they were administered for nutrition or hydration

K0510: Nutritional Approaches

- A. Parenteral/IV feeding (see clarifications, next slide)
- B. Feeding tube – nasogastric or abdominal (PEG)
- C. Mechanically altered diet
- D. Therapeutic diet
  - Ordered as part of treatment for disease or condition manifesting an altered nutritional status to eliminate, decrease, or increase certain substances in the diet, e.g., sodium or potassium
  - Defined by why it is required, not its content
  - A nutritional supplement is not a therapeutic diet but may be part of one
  - Food elimination diets r/t to food allergies (e.g., peanut allergy) can be coded here

- Z. None of the above
K0510A: Parenteral/IV Feeding
- IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration
- Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record
- May be: IV fluids, hyperal, TPN, IV fluids running at KVO, IV fluids contained in IV Piggybacks, Hypodermoclysis and subcutaneous ports in hydration therapy
- Do not include:
  - IV medications, IV fluids used to reconstitute and/or dilute medications for IV administration
  - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
  - IV fluids administered solely as flushes
  - Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis

K0710: Percent Intake by Artificial Route

K0710A: Proportion of Total Calories Received Through Parenteral or Tube Feeding

- If resident has IV and/or tube feeding and took nothing by mouth or only sips of fluids, then K0710A = “3”, 51% or more by parenteral or enteral route
- If resident had more oral intake than that, a calorie count will be needed and proportion of total calories will be calculated:
  \[
  \frac{\text{TPN + enteral calories}}{\text{TPN + enteral + oral calories}}
  \]

Coding options:
1. 25% or less
2. 26-50%
3. 51% or more
Nutritional Status Care Area Assessment

- Section K items that trigger:
  - Weight Loss
  - Weight Gain
  - Nutritional Approaches
- Other MDS items can also trigger
- To properly work the care area assessment can also require you to consider additional information that isn't on the MDS, i.e., fear that food is being poisoned
- The RAI manual requires us to discuss each triggered care area with the resident and their family or significant other