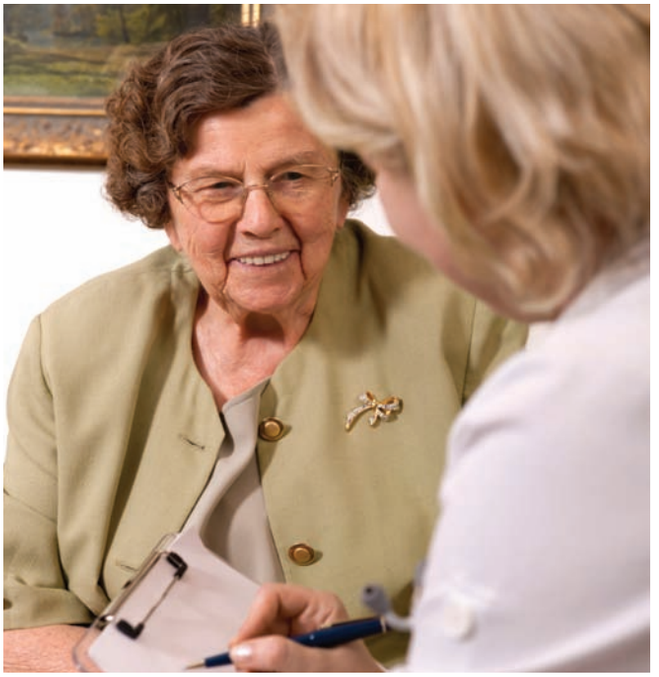

UNDERSTANDING CARE AREA ASSESSMENT

New CMS Rules Impact Food and Nutrition Care for Residents

By Barbara Thomsen, CDM, CFPP, RAC-CT, and Deb Ruebbelke, RD, LD

"Quality of life can be greatly enhanced when care respects the resident's choice regarding anything that is important to the resident..." — Centers for Medicare & Medicaid Services, 2010 MDS 3.0

George, an elder gentleman, followed a morning routine while living at home. He enjoyed waking up late, reading the newspaper, and drinking coffee before getting dressed for the day. But once he became ill and was admitted to a long-term care facility, his morning routine came to a screeching halt. Instead, he had to conform to the facility's rules and regulations, which weren't conducive to his way of life. George had to wake up early so a staff member could dress him to ensure he'd arrive to eat breakfast at 7 AM. He no longer could read the newspaper or drink coffee at his leisure before breakfast. As you can imagine, he became frustrated with his lack of freedom, but he had little say in the matter.

George's experience was all too common in long-term care facilities, where residents didn't have much influence in the planning of their daily schedules or in the care they received. The good news is that all of this has changed.

Last year, the Centers for Medicare & Medicaid Services (CMS) released new guidelines for care area assessments (CAAs) in long-term care facilities under MDS 3.0—developed for nutrition professionals to use in care planning and quality improvement. The new guidelines give residents a voice in scheduling their daily activities and in the care they receive, and will have a significant impact on how nutrition professionals interact with residents and one another and on how they do their jobs.

Under MDS 3.0, George enjoys reading his daily paper before breakfast while drinking coffee at his bedside and lounging in his pajamas until it's time to get ready for the second dining room service beginning at 9 AM—not 7 AM. That's because a nutrition professional took the time to ask him about his care preferences and will do so regularly to determine whether George wants to make any changes concerning his care.

Unlike the new person-centered MDS 3.0 guidelines, the former rules under MDS 2.0 didn't focus on the residents' individual needs; instead, they were designed to be a one-size-fits-all, institutionalized medical model for long-term care. This article will review some of the new guidelines surrounding CAAs and how they'll impact food and nutrition care and the lives of residents.

MDS 3.0 Explained

In accordance with MDS 3.0, nutrition professionals must complete a thorough resident assessment and a CAA and develop a care plan if necessary—all while focusing on the individual needs of the resident.

The nutrition team performs CAAs shortly after residents are admitted to a long-term care facility. During this time, the team interviews residents to obtain information about the condition of their health and personal preferences concerning their care. They ask questions using the MDS 3.0 assessment tool to evaluate the resident's clinical and psychosocial well-being. The assessment tool also helps identify critical areas concerning the residents' health, known as care area triggers (CATs), which need special attention. These CATs help the nutrition team make care planning decisions. The team assesses all CATs, although not all may need to be addressed in the written care plan if the health concerns don't negatively affect the residents' overall condition.

For example, a resident may tell a certified dietary manager (CDM) and an RD that she's been "pleasantly plump" her entire life but in the last several years has been able to maintain her weight +/- 5 lbs. On her MDS assessment, she triggers what's called "a nutritional status CAA for a BMI greater than 24.9." In this instance, an RD and a CDM would address the BMI on the resident's care plan. The dietitian wouldn't have to perform a CAA, as the resident's weight has no adverse effect on her condition. Moving forward, staff would monitor the resident's weight monthly. The resident's goal would be to continue maintaining her current weight and BMI, and she'd be able to choose her meals based on her preferences.

In another instance, a resident may have been on dialysis therapy for many years and receives diuresis medication. In between the time he receives dialysis, he has episodes of fluid buildup and weight gain. His weight fluctuations trigger "a nutritional status CAA for weight loss/weight gain of 5% or more in the past 30 days." With the diuretics and renal issues already addressed in the clinical record, an RD or a CDM would write the CAA to include a physician-prescribed weight loss regimen with the expected outcome of weight loss related to his renal diagnosis. This is a new occurrence under MDS 3.0 that accounts for those residents who are susceptible to weight gain related to a medical condition or who are following a planned weight loss regimen; it prevents their condition from being viewed as a negative adverse outcome.

Residents Have a Voice

The interview process under MDS 3.0 gives residents living in long-term care facilities a much-needed voice in their care decisions. RDs and CDMs listen to residents, get to know them, and inform them of their rights as residents. No longer do clinical conditions determine how RDs and CDMs care for individuals; now they ask residents what steps they can take to improve their care.

The most positive change that's taken place is that facilities have redirected attention away from all the paperwork under MDS 2.0 and placed it solely on the resident. Residents become active participants in their care, which lifts their mood, preserves their dignity, and increases their involvement in scheduling daily activities. What's more, nutrition professionals can work more effectively in interdisciplinary teams to meet all the residents' needs.

Team Approach

MDS 3.0 also gives CDMs and RDs a chance to work together as a stronger nutrition support team, since they have more freedom to discuss the different roles they should play and feel comfortable performing to maximize resident care. They can collaborate with one another more effectively to ensure residents have a choice when it comes to dining preferences, daily activities, and their overall quality of life. They can decide who will identify nutrition concerns and make appropriate referrals and provide residents with basic nutrition education. This is a big step forward under MDS 3.0. Dividing important responsibilities between them enhances their working relationship. The goal isn't to diminish either role in the nutrition care planning and documentation process concerning the residents but to build a stronger team that can work in tandem to provide optimal care and nutrition support.

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CAA POINTERS

Nutrition professionals take the following steps while conducting care area assessments (CAAs) in long-term care facilities:

- **Complete an MDS 3.0 assessment.** This involves a core set of screening, clinical assessment, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid. It also includes patients receiving skilled nursing facility services in noncritical access hospitals with a swing bed agreement.
- **Evaluate care area triggers (CATs).** CATs are a set of items and responses from the MDS that are indicators of particular issues and conditions that affect nursing facility residents. The triggers are specific resident responses for one or a combination of MDS elements. They identify residents who have or are at risk of developing specific functional problems and require further assessment.
- **Perform CAAs.** CAAs involve the review of one or more of the 20 conditions, symptoms, and other areas of concern that are commonly identified or suggested by MDS findings. Care areas are triggered by responses on the MDS item set.
- **Develop a care plan.** Care planning involves establishing a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative), the resident's physician, and an interdisciplinary team that moves a resident toward resident-specific goals, utilizing individual resident strengths and interdisciplinary expertise and crafting the "how" of resident care.
- **Identify the need for a referral.** RDs and CDMs often refer patients to specialists if they identify special health concerns. For example, if an RD or a CDM discovers that a resident holds food in his mouth or cheeks after meals, this could be a sign of dysphagia. In this case, the RD or the CDM would refer the resident to a speech therapist for an evaluation to determine whether the texture of his food needs to be softened to facilitate swallowing.
- **Document** what research, resources, or assessment tools were used in completing the CAA and what plan of care can be developed and revised to improve the residents' status, help them maintain function, and prevent decline. If care planning isn't needed, an explanation must be provided.

— BT, DR