



American Dietetic Association
Your link to nutrition and health.sm

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May 21, 2003

Ms. Rita Shapiro
Division of Ambulatory and Post Acute Care (DAPAC)
Centers for Medicare and Medicaid Services
7500 Security Boulevard Mail Stop S3-02-01
Baltimore, MD 21244

Dear Ms. Shapiro:

Thank you for providing the American Dietetic Association (ADA) the opportunity to comment on the draft revision of the Minimum Data Set Instrument Version 3.0 (dated April 2, 2003). ADA represents almost 70,000 food and nutrition professionals serving the public through the promotion of optimal nutrition, health and well being. ADA appreciates this opportunity to submit formal comments in response to the Centers for Medicare and Medicaid proposed rule on medical nutrition therapy (MNT).

ADA has a history of involvement with the MDS assessment tool. Every nursing facility in the country uses the services of a registered dietitian. We applaud CMS for continuing to streamline the MDS and reduce provider burden and improve the instrument as a clinical assessment tool. Relying on qualified experts from within our Consulting Dietitians in Health Care Facilities who reviewed the draft, we are submitting for your consideration the following comments.

Section B. Cognitive/Behavioral Patterns

B6d – re-categorize “self-abusive acts” and “smearing or throwing of food and feces” to B6c, “Physically Aggressive Behavioral Symptoms.”

B6e – Change to “Resists Care” instead of “Resists The Way Care is Given”. The latter statement implies a problem with staff service rather than behavioral symptoms.

Section F. Quality of Life

F1- Self-Report Quality Of Life. It is expected that some residents will voice concerns with some of the issues addressed in this section regardless of whether a problem can be identified. It is more appropriate to assess whether staff addresses concerns as they are voiced rather than focusing on a few selected topics. The questions could be asked in the following way: Have you had concerns about the following and has staff addressed them?

- a. Privacy Yes or No, Addressed Yes or No
- b. Opportunity for religious activities Yes or No, Addressed Yes or No
- c. Activities of choice Yes or No, Addressed Yes or No
- d. Quality of food Yes or No, Addressed Yes or No
- e. Meal hours Yes or No, Addressed Yes or No
- f. Security of your belongings Yes or No, Addressed Yes or No
- g. Care of your laundry Yes or No, Addressed Yes or No
- h. Personal safety Yes or No, Addressed Yes or No

Section I. Disease Diagnosis

I :2 Infections - add MRSA and VRE

Section K. Swallowing/Nutritional Status

This section is confusing. We consulted with several speech therapists in different states that also found certain areas of this section to be unclear. Under category K1, we recommend the addition of “chewing” to indicate Chewing/Swallowing/Nutritional Status, since it is difficult to separate chewing and swallowing problems. Swallowing problems can be the result of food not being chewed properly.

Also under category K1, we recommend the sub-section “No Helper,” parts 1 and 2 and the sub-section “Helper,” parts 3 through 7, be deleted for the following reasons:

1. It requests assessment data that is not well defined nor readily measured upon observation. For example, under Part 4, it states, “Subject requires 10-25% assistance or supervision for swallowing; AND requires dietary restriction of liquid and solid textures.” Does this measure refer to the percent of time the resident requires supervision or the severity of the swallowing impairment?
2. It includes assessments that only a speech language pathologist can complete, such as safe swallowing.
3. The terminology for diet level, minimal diet restriction and modified diet, are not defined, nor are they part of the generally accepted terminology used by Registered Dietitians.
4. This data has not been demonstrated to correlate with nutritional status across the resident population in skilled facilities.

Factors that have been demonstrated to affect the nutritional status of residents in skilled nursing facilities include depression (1), reduced functional ability, intake of 50% or less of food served for the past 3 consecutive days, and chewing problems (2). The importance of appropriate hydration and the potential effect of dehydration for reducing the intake of solid foods are also critical aspects of care that should be included in the assessment process (3), (4).

A number of the factors identified above are addressed in other sections of the MDS, such as depression and mood in Section E, diminished functional ability in Section G and chewing problems in Section L. The indicators that have not been included in other sections of the MDS include intake of less than 50% for three consecutive days and hydration status.

Therefore, we recommend that section K1, Swallowing/Nutritional Status, include the indicators that are readily measurable on observation and have been demonstrated to impact the nutritional status of residents.

Change section K 1 to Chewing/Swallowing/Nutritional Status to reflect the following parameter:

0. Normal – Safe and efficient chewing/swallowing of all diet consistencies.
1. Requires Diet Modification to Chew and Swallow Solid Foods (mechanical diet cut-up food or able to ingest specific foods only). This would be explained in the RAI Manual.
2. Requires Modification to Swallow Solid Foods and Liquids (puree, thickened liquids).
3. Combined Oral and Tube Feeding Only.
4. Parenteral/Tube Feeding Only.
5. No Oral Intake (NPO) and No Tube Feeding.

K2. Height and Weight

We are pleased to see that height is only collected upon admission. Even if the resident's stature becomes reduced due to osteoporosis, the same nutritional needs must still be maintained. We suggest changing "Base weight on most recent measure in last three days" to "last 30 days." This measurement takes into account both skilled and nursing facility admission.

K4. Nutritional Approaches

K4e. Change Dietary Supplements Between Meals to Dietary Supplements. Residents who do not consume enough of their meal will often take a supplement at the end of meal service before they leave the dining room.

K4f. The descriptor, "On a planned weight change program" needs a better explanation in the RAI manual.

K4 Add another descriptor - "Leaves 50% or more of food uneaten."

Section L Oral Status and Disease Prevention

L1.b Resident has chewing problems - move to section K1

L1.e Change "Resident has a problem with or may need a denture or partial denture," to "Resident has poorly fitting dentures or partial plates." What does "has a problem with" actually mean?

L1.g Change "Resident has natural teeth or tooth fragments" to "Resident has natural teeth in good condition."

L1h Change "Resident has an obvious cavity(s) or a broken natural tooth (teeth)" to "Resident has numerous missing natural teeth, tooth fragments, obvious caries or broken teeth."

Section M Skin Condition

This section is much improved and well done.

Thank you for considering these comments on your draft version of the MDS 3.0. We are always available to provide assistance on any food and nutrition issues in long term care. Please call Judy Dausch at (202) 775-8277 in ADA's Washington office if you have any questions or need additional information.

Sincerely,

Judith G. Dausch, Ph.D., R.D.
Senior Manager for Regulatory Affairs

Cc: Ann Gallagher, RD, LD
Consultant Dietitians in Health Care Facilities/ADA Liaison

Comments of Ann Gallagher, RD, LD
American Dietetic Association

The American Dietetic Association the largest nutrition organization in the United States appreciates the opportunity to comment on the draft version of the MDS 3.0 dated April 2003. We have over 70,000 members. Every nursing facility in the country uses the services of a registered dietitian. We applaud CMS for continuing to streamline the MDS and improve the instrument as a clinical assessment tool. We are submitting for your consideration the following comments:

Section B Cognitive/Behavioral Patterns

B6d – Change Self Abusive acts smearing and throwing food and feces to Physically Aggressive Behavior

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Section F Quality of Life

F1- Self-Report Quality Of Life It is expected that some residents will voice concerns with some of the issues addressed in this section regardless of any finding of a problem. Considering this, it is more appropriate to assess if staff address the concerns as they are voiced rather than focusing on a few selected topics. The question could be asked in the following way. Have you had concerns about the following and has staff addressed them?

- i. Privacy Yes or No, Addressed Yes or No
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Section I Disease Diagnosis

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Section K Swallowing/Nutritional Status

This section is very confusing. We checked with several Speech Therapist and they were just as confused

Recommend – Chewing/Swallowing/Nutritional Status. It is difficult to separate chewing and swallowing problems. Swallowing problems can be the result of food not being chewed properly.

K I Recommend The sub-section no Helper, 1 and 2 and Helper 3-7 be deleted for the following reasons.

5. It requests assessment data that is not well defined nor readily measured on observation, e.g. ...”% assistance and supervision for swallowing”. Is this the percent of time the resident requires supervision or the severity of the swallowing impairment?
6. It includes assessments that only a Speech Language Pathologist can complete, e.g. safe swallowing.
7. The terminology for diet level and minimal diet are not defined nor are they part of the generally accepted terminology used by registered Dietitians.
8. This data has not been demonstrated to correlate with nutrition status across the resident population in skilled facilities.

Factors that have been demonstrated to affect the nutritional status of residents in skilled nursing facilities include depression reduced functional ability, intake of 50% or less of food served for the past 3 consecutive days, and chewing problems. The importance of appropriate hydration and the potential effect of dehydration reducing the intake of solid foods are also critical aspect of care that should be included in the assessment process. A number of the factors identified above are addressed in other sections of the MDS, depression in Section E-Mood, diminished functional ability in section G –Functional Status, chewing problems in section L Oral Status and dehydration in section J Problem Conditions

Therefore, we recommend that section K 1 Swallowing and Nutritional Status include the indicators that are readily measurable on observation and have been demonstrated to impact the nutrition status of residents

Change section K 1 to Chewing / Swallowing Nutritional Status

6. Normal – Safe and efficient chewing / swallowing of all diet consistencies.
7. Requires Diet Modification to Chew and Swallow Solid Foods (mechanical diet cut up food or able to ingest specific foods only) This would be explained in the RAI Manual
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K2. Height and Weight

Pleased to see that height is only collected on admission. If the resident shrinks from osteoporosis, needs are still the same.

“Base weight on most recent measure in last three days” recommend change to “last 30 days” – that takes into account both skilled and nursing facility admissions. The RAI Manual would indicate if a resident has a change in intake or a change in condition. The resident should be weighed again during the observation period for completing the assessment.

K4e. Nutritional Approaches

Change Dietary Supplements between Meals to Dietary Supplements. Residents who do not consume enough of their meal will often take a supplement at the end of meal service before they leave the dining room.

K4f On a planned weight program needs a better explanation in the RAI manual

K4 Add Leaves 50% or more of food uneaten

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