

Care Provider Name: \_\_\_\_\_  
Est. Form Completion Time: \_\_\_\_\_

PROJECT TO DEVELOP AN OUTCOME-BASED CONTINUOUS  
QUALITY IMPROVEMENT SYSTEM AND CORE OUTCOME  
AND COMPREHENSIVE ASSESSMENT DATA SET FOR PACE

**DRAFT COCOA DATA SET  
DIETITIAN FORM**

Conducted by:  
The Center for Health Services Research

for:

Department of Health and Human Services  
Centers for Medicare and Medicaid Services

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Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment. Responses to the collection of the information are voluntary.

**DRAFT COCOA DATA SET  
DIETITIAN FORM  
OVERVIEW/PROTOCOL**

**PURPOSE:** The information is being collected as part of a two-site feasibility test for the purpose of testing the feasibility of data collection using the draft core outcome and comprehensive assessment (COCOA) data set for PACE. Proposed data collection protocols will also be tested. The two-site feasibility test will result in the refinement of data items and protocols as appropriate. Findings from this project are intended to guide the anticipated implementation of a national approach for core comprehensive assessment of participants and outcome-based continuous quality improvement (OBCQI), in which PACE sites will collect data that will be used to determine and profile participant outcomes for their site.

**HOW COLLECTED:** This form will be completed by dietitians providing direct care to the participant.

**WHEN COLLECTED:** This form will be completed for each participant at one time point during the two-site feasibility test.

Completion of the form should occur within 24 hours of the provider's assessment of the participant (ideally, the form will be completed as part of the participant's routine assessment).

**INSTRUCTIONS:** This form contains items to be completed by the dietitian (this includes direct response to items and administering items to PACE participants). The dietitian will complete the form and will record responses directly on the form. The dietitian should mark the correct response as appropriate or print numbers/answers where requested. All items should be completed unless specifically directed to skip items based on a previous response. The Data Collection Coordinator (DCC) assigned at the site will receive the completed forms from the dietitian. The DCC will submit completed forms to the Research Center.

**Note:** Some data items in this form are also included in other COCOA forms. The forms in which the item appears are noted in brackets next to each item. For example, item 5 in this form is included both in this form and the Nursing form, as indicated by [RN, RD] next to the question stem for item 5. The abbreviations for each of the COCOA forms are listed below for quick reference.

Intake = Intake Form; HEA = Home Environment Assessment Form; PCP = Primary Care Provider Form; RN = Nursing Form; REHAB = Rehabilitation Therapy Form; SW = Social Work Form; RT = Recreational Therapy Form; RD = Dietitian Form; PSQ = Participant Satisfaction Form; CSQ = Caregiver Satisfaction Form; EOL = End of Life Form; UTIL = Utilization Form.

# Two-Site Feasibility Test

## DRAFT DIETITIAN FORM

Site ID \_\_\_\_\_ Participant ID \_\_\_\_\_

1. **Participant Name:** [ALL]

(Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Suffix) \_\_\_\_\_

2. **Reason for Assessment:** [HEA, PCP, RN, REHAB, SW, RT, RD, PSQ, CSQ]

- ☐ 1 - Initial assessment  
☐ 2 - Reassessment  
☐ 3 - Annual reassessment

3. **Date Assessment Completed:** [INTAKE, HEA, PCP, RN, REHAB, SW, RT, RD, EOL, UTIL]

\_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year

4. **Participant Goals: (Ask participant.)** What would you like to change or accomplish over the next few months that we can help you with? [PCP, RN, REHAB, SW, RT, RD]

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

☐ UA - This information could not be obtained due to participant's cognitive impairment

5. **Height and Weight:** [RN, RD]

- a. Record actual **height** in inches (measured) HEIGHT (in.) \_\_\_\_\_  
b. Record actual **weight** in pounds or kilograms (measured) WEIGHT (lb.) \_\_\_\_\_ or (kg.) \_\_\_\_\_

6. **Weight Gained/Lost** since last assessment: (please use "+" to indicate a weight gain or "-" to indicate a weight loss). [RN, RD]

\_\_\_\_\_ lbs. OR \_\_\_\_\_ kg.

7. **Special Diet:** [RD]

- a. Is the participant following any special diet(s)? ☐ 0 - No [ Go to Item 8 ] ☐ 1 -Yes

- b. Indicate below type of special diet and if doctor prescribed. (Mark all that apply.)

	Check if following this Special Diet	Check if Doctor Prescribed
Tube feeding (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>
Low sodium (salt)	<input type="checkbox"/>	<input type="checkbox"/>
Low sugar	<input type="checkbox"/>	<input type="checkbox"/>
Low fat/cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Renal	<input type="checkbox"/>	<input type="checkbox"/>
Calorie controlled	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition supplements	<input type="checkbox"/>	<input type="checkbox"/>
Six small meals daily	<input type="checkbox"/>	<input type="checkbox"/>
Vegetarian	<input type="checkbox"/>	<input type="checkbox"/>
Ground	<input type="checkbox"/>	<input type="checkbox"/>
Soft	<input type="checkbox"/>	<input type="checkbox"/>
Thickened Liquids	<input type="checkbox"/>	<input type="checkbox"/>
Pureed	<input type="checkbox"/>	<input type="checkbox"/>
Ethnic/religious	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>

Notes (optional): \_\_\_\_\_

8. **Typical Diet:** (Ask participant or informal caregiver if participant is unable to respond due to cognitive impairment.) Describe what you usually eat and drink during a typical day (including snacks and food on weekends): **[RD]** \_\_\_\_\_

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9. **Nutrition:** Which response best describes the participant's usual food intake pattern? **[RN, RD]**

- ☐ 0 - **Excellent** – Eats most of every meal. Never refuses a meal. Usually eats a total of four or more servings of meat and dairy products per day. Occasionally eats between meals. Does not require supplementation.
- ☐ 1 - **Adequate** – Eats over half of most meals. Eats a total of four servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN regimen that probably meets most of nutritional needs.
- ☐ 2 - **Probably Inadequate** – Rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only three servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.
- ☐ 3 - **Very Poor** – Never eats a complete meal. Rarely eats more than a third of any food offered. Eats two servings or less of protein (meat or dairy products) per day. Does not take a liquid dietary supplement, OR is NPO and/or maintained on clear liquids or IVs for more than five days.

10a. **Nutritional Risk:** **[RN, RD]**

	0 - No	1 - Yes
1. Do the medical conditions or illnesses limit or change the amount of food the participant eats? (list conditions): _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the participant eat fewer than two meals per day?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the participant eat few fruits, vegetables and/or milk products?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the participant have poor dentition that makes eating difficult?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the participant consume alcohol on a daily basis?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the participant lack funds to purchase food?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the participant usually eat alone?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the participant take more than three prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the participant lost or gained more than 5% of their body weight in the last month, or more than 10% in the last six months?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the participant lack the means or ability to procure, store or prepare foods?	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the participant unable to feed him/herself?	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the participant's appetite poor?	<input type="checkbox"/>	<input type="checkbox"/>

Assessment of Nutritional Risk (Sum of "Yes" Responses): \_\_\_\_\_

Scoring:

- 0 "Yes" responses = person unlikely at nutritional risk  
1-2 "Yes" responses = person likely at low nutritional risk  
3-5 "Yes" responses = person likely at moderate nutritional risk  
6+ "Yes" responses = person likely at high nutritional risk

Notes (optional): \_\_\_\_\_

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b. **Nutritional Risk:** Circle the item scores that best represent the participant's status. [RD]

<u>Risk Factors</u>	<u>Score</u>
<i>Unintentional</i> weight loss	
If >10% of usual weight in 3 months.....	5
Percentage of IBW:	
10-15% below.....	3
>15% below.....	5
20-30% over.....	1
>30% over.....	2
Albumin (within yr) 3.0-3.4 gm/dL.....	3
<3.0 gm/dL.....	4
Tube feeding.....	2
Impaired skin integrity	
Stage 1.....	1
Stage 2.....	2
Stage 3.....	6
Stage 4.....	7
Identified swallowing problem.....	3
Oral/dental problem contributing to inability to eat.....	1
Uncontrolled Diabetes Mellitus.....	3
(CBG consistently over 250mg/dL or wide fluctuations in readings)	
Living independently - unable to meet nutritional needs (meal planning, shopping, cooking).....	2
Increased nutritional needs (due to acute illness, deconditioning/hospitalization, etc.).....	3
Consistently inadequate P.O. intake (<50% over one month).....	2
TOTAL SCORE (add up item scores):_____	
11 or above = High Risk	
6-10 = Moderate Risk	
3-5 = Low Risk	
0-2 = Stable Nutritional Status	

11. **Feeding or Eating:** Performance (what participant actually does) and ability (what participant is capable of doing) to feed self meals and snacks. Note: This refers only to the process of eating, chewing, and swallowing, NOT preparing the food to be eaten. [RN, REHAB, RD]

<u>Perfor-</u> <u>mance</u>	<u>Ability</u>	Definitions and illustrative circumstances:
<input type="checkbox"/>	<input type="checkbox"/> 0 - Feeds/eats independently	<ul style="list-style-type: none"> <li>Feeds self/eats without any assistance or supervision all of the time.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/> 1 - Feeds/eats independently but needs <u>some</u> assistance	<ul style="list-style-type: none"> <li>Feeds self independently but requires:               <ul style="list-style-type: none"> <li>(a) meal set-up; <u>OR</u></li> <li>(b) intermittent assistance or supervision (e.g., cueing) from another person; <u>OR</u></li> <li>(c) an assistive device (e.g., utensil with built-up handle, plate guard, or cup with spout to prevent spilling); <u>OR</u></li> <li>(d) a liquid, pureed or ground meat diet.</li> </ul> </li> </ul>
<input type="checkbox"/>	<input type="checkbox"/> 2 - Does not feed/eat independently and <u>needs assistance</u>	<ul style="list-style-type: none"> <li>Must be assisted or supervised throughout meal/snack.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/> 3 - Takes in nutrients orally and by tube feeding	<ul style="list-style-type: none"> <li>Takes in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/> 4 - Completely dependent on nasogastric tube or gastrostomy	<ul style="list-style-type: none"> <li>Does not take nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/> 5 - Does not take in nutrients orally or by tube feeding	<ul style="list-style-type: none"> <li>Receives total parenteral nutrition (TPN).</li> </ul>

Notes (optional): \_\_\_\_\_

**PROVIDER: Respond to Item 12 below.**

12. **Provider Suspicion of Participant Abuse:** Based on your experience and interactions with the participant, is there reason to suspect any of the following? **(Mark all that apply.)** [PCP, RN, REHAB, SW, RT, RD]

- ☐ 1 - Physical Abuse: beating, over-medication, restraining, etc.
- ☐ 2 - Denial of Basic Needs: withholding of food, clothing, hygiene, lack of supervision, abandonment
- ☐ 3 - Psychological Abuse: verbal assaults, insults, threats, and isolation
- ☐ 4 - Material Abuse: thefts, misuse of funds, fraud, etc.
- ☐ 5 - Violation of Rights: coercion, locking in, etc.
- ☐ 6 - Self-Neglect: substandard housing, failure to obtain adequate medical care, food, or protection
- ☐ 7 - None

Notes (optional): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please respond to the evaluation questions and return  
completed materials to the Data Collection Coordinator at your site.**

**Thank you for your participation.**