

A 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:
Center for Health Services Research
University of Colorado Health Sciences Center

for:

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0791. The time required to complete this information collection is estimated to vary from four to six minutes with an average of five minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

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.

Site ID

Participant ID

FIRST PHASE RELIABILITY TEST DRAFT DIETITIAN FORM

1. **Participant Name:** _____
(Last) (First) (MI) (Suffix)
2. **Date Assessment Completed:** ____/____/____
month day year
3. **Reason for Assessment:**
- ☐ 1 - Initial assessment
- ☐ 2 - Reassessment
- ☐ 3 - Annual reassessment
4. **Staff Member Who Completed Assessment (Name):** _____
5. **Participant Goals: (Ask participant.)** What would you like to change about your diet, nutritional status, or weight over the next few months that we can help you with?
- _____
- _____
- _____
- ☐ UA - This information could not be obtained due to participant's cognitive impairment
6. **Height and Weight:**
- a. Record actual **height** in inches (measured) HEIGHT (in.) _____ or feet _____ in. _____
- b. Record actual **weight** in pounds or kilograms (measured) WEIGHT (lb.) _____ or (kg.) _____
7. **Weight Gained/Lost** since last assessment: (please use "+" to indicate a weight gain or "-" to indicate a weight loss).
- Gained:** ____ lbs. OR ____ kg.
- Lost:** ____ lbs. OR ____ kg.
- Notes (optional): _____
8. **Hydration:** In the past 24 hours, the patient's approximate **Oral Fluid Intake** was:
- ☐ 0 - 6 cups or more (more than 1200 cc or 48 oz.)
- ☐ 1 - 2-5 cups (480-1200 cc or 16-47 oz.)
- ☐ 2 - Less than 2 cups (less than 480 cc or 16 oz.)
- ☐ NA - Unable to drink fluids

9. **Special Diet:** Indicate type of special diet recommended for or followed by the participant. **(Mark all that apply.)**

	Check if Health Care Provider recommended	Comments
<input type="checkbox"/> 0 - No special diet	<input type="checkbox"/>	_____
<input type="checkbox"/> 1 - Tube feeding (type): _____	<input type="checkbox"/>	_____
<input type="checkbox"/> 2 - Low sodium (salt)	<input type="checkbox"/>	_____
<input type="checkbox"/> 3 - Low sugar	<input type="checkbox"/>	_____
<input type="checkbox"/> 4 - Low fat/cholesterol	<input type="checkbox"/>	_____
<input type="checkbox"/> 5 - Renal	<input type="checkbox"/>	_____
<input type="checkbox"/> 6 - Lactose intolerant	<input type="checkbox"/>	_____
<input type="checkbox"/> 7 - Calorie controlled	<input type="checkbox"/>	_____
<input type="checkbox"/> 8 - Nutrition supplements	<input type="checkbox"/>	_____
<input type="checkbox"/> 9 - Six small meals daily	<input type="checkbox"/>	_____
<input type="checkbox"/> 10 - Ground	<input type="checkbox"/>	_____
<input type="checkbox"/> 11 - Soft	<input type="checkbox"/>	_____
<input type="checkbox"/> 12 - Thickened Liquids	<input type="checkbox"/>	_____
<input type="checkbox"/> 13 - Pureed	<input type="checkbox"/>	_____
<input type="checkbox"/> 14 - Vegetarian	<input type="checkbox"/>	_____
<input type="checkbox"/> 15 - Ethnic/religious	<input type="checkbox"/>	_____
<input type="checkbox"/> 16 - Other (specify): _____	<input type="checkbox"/>	_____

Notes (optional): _____

10. **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):

Breakfast: _____

A.M. Snack: _____

Lunch: _____

Aft. Snack: _____

Dinner: _____

P.M. Snack: _____

11. **Nutrition:** Which response best describes the participant's usual food intake pattern?

- ☐ 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.

12a. **Nutritional Risk:**

	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): _____

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

<u>Risk Factors</u>	<u>Score</u>
<i>Unintentional weight loss</i>	
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	

The next two items should be answered based on the past week. Mark one box for performance and one box for ability.

13. **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.

<u>Performance</u>	<u>Ability</u>	Definitions and illustrative circumstances:	
<input type="checkbox"/>	<input type="checkbox"/>	0 - Feeds/eats independently	• Feeds self/eats without any assistance or supervision all of the time.
<input type="checkbox"/>	<input type="checkbox"/>	1 - Feeds/eats independently but needs <u>some</u> assistance	• Feeds self independently but requires: (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision (e.g., cueing) from another person; <u>OR</u> (c) an assistive device (e.g., utensil with built-up handle, plate guard, or cup with spout to prevent spilling); <u>OR</u> (d) a liquid, pureed or ground meat diet.
<input type="checkbox"/>	<input type="checkbox"/>	2 - Does not feed/eat independently and <u>needs assistance</u>	• Must be assisted or supervised throughout meal/snack.
<input type="checkbox"/>	<input type="checkbox"/>	3 - Takes in nutrients orally and by tube feeding	• Takes in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
<input type="checkbox"/>	<input type="checkbox"/>	4 - Completely dependent on nasogastric tube or gastrostomy	• Does not take nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
<input type="checkbox"/>	<input type="checkbox"/>	5 - Does not take in nutrients orally or by tube feeding	• Receives total parenteral nutrition (TPN).

Notes (optional): _____

14. **Planning and Preparing Light Meals:** Performance (what the participant actually does) and ability (what the participant is capable of doing) to plan and prepare light meals such as cereal, sandwich or reheat delivered meals.

<u>Performance</u>	<u>Ability</u>	Definitions and illustrative circumstances:	
<input type="checkbox"/>	<input type="checkbox"/>	0 - (a) Independently plans and prepares all light meals for self or reheats delivered meals; <u>OR</u> (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past.	
<input type="checkbox"/>	<input type="checkbox"/>	1 - Does not prepare light meals on a regular basis due to physical, cognitive, or mental limitations.	
<input type="checkbox"/>	<input type="checkbox"/>	2 - Does not prepare any light meals or reheat any delivered meals due to physical, cognitive, or mental limitations.	

Notes (optional): _____

The following information should be completed by the PACE care provider or staff member after completing the COCOA form.

1. Estimated form completion time (in minutes): _____
2. Approximate time of day assessment completed:
☐ 1 - Morning
☐ 2 - Afternoon
☐ 3 - Evening
3. Location where assessment was completed:
☐ 1 - Day health center [**Go to Item 4**]
☐ 2 - Participant residence [**Stop Here**]
4. Is this a day the participant typically attends the day health center?
☐ 0 - No
☐ 1 - Yes

**Please return the completed form to your site's Data Collection Coordinator.
Thank you for your participation.**