Disclosures

Faculty	Consultant	Speaker's Bureau	Grants
Terese Scollard	No relevant financial relationships to disclose.		
Kelly Tappenden	Abbott Nutrition NPS Pharmaceuticals	Nutricia	Nestlé Abbott Nutrition

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Regional Clinical Nutrition Manager

Providence Health & Services

Portland, OR

OBJECTIVE

3. **Demonstrate how consistent documentation enables clinicians to establish prevalence and initiate effective nutrition interventions and outcomes.**

OUTLINE

1. Clinical 'Hot Topics'
   - Background and refresher
   - Coding questions
   - Albumin and pre-albumin
   - Documentation techniques
   - Changes in type of malnutrition
   - Grip Strength
   - Intake comparisons
2. Operations & Systems 'Hot Topics'
   - ICD-9 CM
   - Workflow
   - BMI and Morbid Obesity
   - Rejections
   - Leading statements
   - Common questions
3. Action: Examples & Outcomes
   - Looking at the problem differently
   - Waiting until hospitalization?
   - Economics and healthcare costs

QUESTION: How many years has your place of employment had a work flow process in place to identify and track adult patients who are medically diagnosed with malnutrition?

A. Do not track
B. 1-3 years
C. 3-5 years
D. 5-10 years
E. 10-15 years
F. Greater than 15 years

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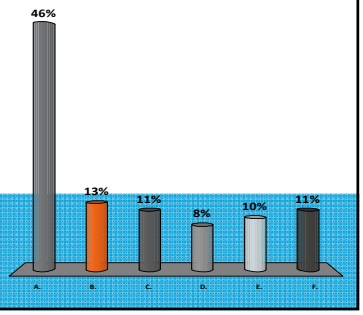

From Theory to Practice: Optimizing Recognition and Documentation of Adult Malnutrition

This event was presented as a live webinar on Wednesday, May 23, 2012.

Event code: 18359
CPE Hours: 2.0
CPE Level: 2.0
Suggested Learning Need Codes: 5280, 5380, 3010, 1065

https://www.eatright.org/shop/product.aspx?id=6442470053

Sample documents, detailed suggestions for operations

QUESTION: When documenting nutrition care for adult patients, do you document data that includes characteristics of severe and moderate malnutrition as described in the Academy/ASPEN Consensus statement 5/2012?

A. Yes
B. No
C. No, but plan to in future

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A. Yes
B. No
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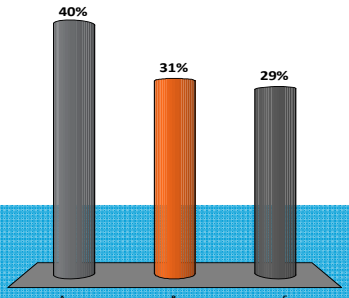


CONSEQUENCES OF UNRECOGNIZED MALNUTRITION

- Increased length of stay
- Impaired wound healing
- Increased morbidity/mortality
- Increased muscle loss/functional loss
- Higher infection/complication rates
- Increased admission/readmission rates

Increased Costs

Int J Environ Res Public Health 2011;8:514-527

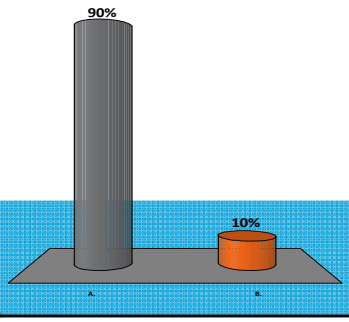
Slide from Academy of Nutrition and Dietetics 5/23/12 Teleseminar "From Theory to Practice: Optimizing Recognition and Documentation of Adult Malnutrition"

QUESTION: It is within the Scope of Practice of a registered dietitian to make a nutrition diagnosis of malnutrition for an adult patient.

A. True
B. False

QUESTION: It is within the Scope of Practice of a registered dietitian to make a nutrition diagnosis of malnutrition for an adult patient.

A. True
B. False



WHO CAN DIAGNOSE?

Medical Diagnosis
- Licensed Independent Practitioner
- Medical Doctor, Doctor of Osteopathy, other LIP

Nutrition Diagnosis
- Within the Scope of Practice of a Registered Dietitian, Licensed or Certified Dietitian
- Defined by the Academy of Nutrition and Dietetics International Dietetics & Nutrition Terminology 4th ed.

King L. JAMA 1967;202:714-717

CLINICAL 'HOT TOPICS'

Etiology Based Malnutrition

+

The Academy/ASPEN Adult Malnutrition Consensus

=

Improved patient recognition, standardization of understanding, Interventions, outcomes and research!

Table 22–3. Protein-calorie Malnutrition

	Marasmus	*Kwashiorkor*
Clinical setting	↓ Calories	↓ Protein + stress
Time course to develop	Months—years	Weeks—months
Clinical features	Starved appearance weight/height < 80% std triceps skinfold < 3 mm midarm muscle circumference < 15 cm	Well nourished appearance hair easily pluckable edema
Laboratory findings	Serum albumin > 2.8 gm per 100 ml	Serum albumin <2.8 gm per 100 ml Serum transferrin < 150 mg per 100 ml Lymphocytes <1200 cells per cu mm Nonreactive skin tests
Clinical course	Reasonably preserved responsiveness to short-term stress	↓ Wound healing ↓ Immunocompetence ↑ Infectious/other complications
Mortality rate	Low (unless related to underlying disease process)	High

Modern Nutrition in Health and Disease, 6th ed. Chapter 22
"Malnutrition in Hospital Patients: Assessment and Treatment"
C.E. Butterworth, Jr. and Roland Weinsier
1978 Lea & Febiger, Philidelphia

ALBUMIN/PRE-ALBUMIN

"Pre-albumin levels decrease likely due to poor nutrition"

- Remains in textbooks and publications
- Challenging to use other phrasing after so long a pattern
- A measure of morbidity and mortality
- Much used leverage for over 30 years to prompt treatment action
- See The Academy Evidence Analysis Library

...so what do we do now to get action?

EXAMPLE

"Pre-albumin levels decreasing likely due to poor nutrition"

Instead try.....

"Patient with inadequate and decreased oral intake as evidenced by chronic mouth pain, decreased appetite and inadequate oral intake for recent 3 months; obvious muscle wasting on extremities, severe weight loss of 26% (58 lbs) in last 2 1/2 months."

"What is quality documentation?"

Weak documentation:
Vague, non-specific, poorly descriptive, 'vernacular', patterns of habit—easier for the writer.

Strong documentation:
Patient centered, for other readers:
Quantifies data, summarizes and organizes; handoffs and transitions, specific and descriptive to patient's situation and condition so reader has vivid understanding of key points for comparison, tracking and next steps; Supports return to improved life circumstances and to prevent readmissions, slow declines, and is respectful to end of life support.

"Can Patient change from one type of malnutrition and one level of severity to another?"

Yes

82 year old female, original height 5' 2"—now 4'11", stable, chronically under weight and lost 2 lbs. over the last year, to 84 lbs.,. Working at a clerical job part time, living on own, gardens, not interested in food, cooking or eating, struggled with under weight and restrictive eating entire life, does not like to socialize outside of family.

Slips and falls and breaks her hip requiring surgery.

Chronic social/environmental type who becomes an acute type, at higher risk for infection, complications than a healthy weight peer.

"How do you tell if malnutrition is getting better or worse in an adult?"

- Use the Academy Nutrition Care Process and IDNT
- Be active with Patient's Interdisciplinary Care Plan
- Compare patient situation to standards such as Academy/ASPEN Characteristics
- Relationship of food intake, functional status, weight to time as time passes
- Interruption by medical/surgical condition or social/personal situation
- Addition or discontinuation of enteral or parenteral nutrition
- Mental status changes
- Addition or discontinuation of oral medical nutritional supplement

"Why do we need to know the different types & severities of malnutrition?"

- Makes a difference in how nutritional repletion is managed
- The patient's metabolic response is different
- Monitoring critical laboratory values may differ
- Interventions are different
- Etiology is different, interventions are different—so impacts outcome

"Do we have to use hand grip strength?"

- It was the strongest functional assessment data in literature review
- It is an option to test functional ability, reasonable, and might be useful in some settings & patient populations
- Markers may change as research and progress is made
- Some patient populations more practical than others
- Need adequate clinical evidence to recognize type and severity, interventions and measurable markers to show functional improvement, maintenance or decline.

"Can we use other professionals' data like RN, PT or OT?"

Yes!

Example: Hand grip strength may be tested by a Physical Therapist or Occupational Therapist

…is a proxy for lean mass and functional capacity

Other functional test results may be considered in a nutritional assessment

"Why the variation in % and time?"

Severe

For Example: ICD-9 Code 262*	Acute Illness/Injury	Chronic Illness	Social/ Environmental
Energy Intake	≤ 50% for ≥ 5 days	≤ 75% for ≥ 1 month	≤ 50% for ≥ 1 month

Non-Severe/Moderate

For Example: ICD-9 Code 263.0 *	Acute Illness/Injury	Chronic Illness	Social/ Environmental
Energy Intake	< 75% for > 7 days	< 75% for ≥ 1 month	< 75% for ≥ 3 months

- Combination of literature review, practical experience and ability to remember
- As more is learned, these may change… a common place to start
- Not typographical errors

"What drives patient identification?"

- Admission screening process (hospital, clinic, long term care, community settings)
- Include reliable, validated screening tools….
  - Check out The Academy Evidence Analysis Library!
- How many patients are being missed?
- Audit compliance with screening and referrals and include under/malnutrition in patient care plans
- This process remains a compliance challenge in many acute care facilities

BEST PRACTICE: EARLY PATIENT IDENTIFICATION

- **Critical to prevent further patient nutritional failure**
- **RDs must act and advocate:**
  - At policy and procedure level
    - Validated screening tools, integrated with team
  - In facility practice and staff education
  - In discharges and handoffs and transfers

OPERATIONS & SYSTEMS "HOT TOPICS"

BRIDGES TO A UNIFIED SYSTEM**



Adult Malnutrition
- Clinical presentation
- Will change
- Altered Metabolic Status
- Treatment specific to pre-disposing factors:
  - Starvation
  - Chronic disease
  - Acute disease or injury

Tools to Bridge
- Work of Academy & ASPEN
- Reasonable & reliable literature and research-based criteria at this time
- Will change with further clinical understanding
- NOT the "be-all end-all" for adult malnutrition

ICD Classification*
- A system to categorize and communicate adult malnutrition
- Allows for benchmarking prevalence

*2012 ICD-9-CM Physician Volumes 1 and 2. American Medical Association
**Slide from Academy of Nutrition and Dietetics 5/23/12 Webinar: *From Theory to Practice: Optimizing Recognition and Documentation of Adult Malnutrition*-Scollard

REMINDER: MALNUTRITION WORK FLOW

Upon admission, patients are screened/referred by Nursing, or MD order

↓

Registered Dietitian (RD) assesses patients with nutrition risk factors

↓

RD reviews malnutrition findings with MD/LIP

Team collaborates on plan of care with documentation

↓

Upon discharge, Coders review medical records & assign ICD-9 codes which are the means of providing data and

Reimbursement to hospitals

(learn specifics and details in Academy 5/2012 Tele-seminar)

*Slide from Academy of Nutrition and Dietetics 5/23/12 Webinar: *From Theory to Practice: Optimizing Recognition and Documentation of Adult Malnutrition*

INPATIENT PROSPECTIVE PAYMENT SYSTEMS

MS DRG's (medical severity diagnosis related groups)

- MCC-major complication & comorbidity
- CC-complication & comorbidity
- Nutrition codes (weight loss, underweight)

APR DRG other classification system in some states

October 1, 2012:
ICD-9 codes 263.0 = CC & 263.1 = a CC

MAJOR COMPLICATION & CO-MORDIDITY CODES, AND COMPLICATION AND CO-MORBIDITY CODES

MCC's are:

260 Kwashiorkor (pediatrics)
261 Nutritional marasmus (pediatric)
262 Other severe protein calorie malnutrition

The NEW CC's for FY 2013, effective with discharges of 10/1/2012 are:

263.0 Malnutrition of moderate degree
263.1 Malnutrition of mild degree

CC's

263.8 Other protein calorie malnutrition
263.9 Malnutrition, not otherwise specified
BMI >40 codes: V85.41, V8542, V85.43, V85.44, V85.45)
BMI < 19: V85.0 (adult)

"CAN A MEDICAL CODER USE BMI DOCUMENTED BY A REGISTERED DIETITIAN?"

"DOES THE MD HAVE TO ACKNOWLEDGE THIS BMI?"

- Code assignment for BMI may be based on medical record documentation from clinicians who are not the patient's provider (Dietitian or Nurse is the clinician; MD/LIP is the provider)
- The associated diagnosis (such as overweight, obesity) must be documented by the patient's provider
- BMI codes should only be reported as secondary diagnoses.

AHA Coding Clinic (only source of official coding advice)

(see specific text in *Notes* section at end of slide set)

"What if there is a CODING REJECTION?"
…a rejection letter might look like this…

The dietitian included a form diagnosing the patient with Kwashiorkor in which the form was signed by the physician. The patient had a stated inadequate nutritional intake for 10 days with a 5 lb weight loss over 1-2 weeks. The patient had a protein level of 6.3 and albumin of 2.8. Patient BMI was 24.5 with IBW at 118%. The patient was prescribed an oral nutritional supplement and vitamin supplements. There were no signs or symptoms to indicate a diagnosis of Kwashiorkor. The documentation in the medical record does not support Kwashiorkor but is indicative of moderate malnutrition.

"What is a leading statement or query?"

- Cannot use language so that the MDs would answer that the patient was malnourished.
- **Work closely** with your Medical Coders, Documentation Improvement Specialists and physicians to make sure malnutrition recognition processes and forms do not 'lead' the MD to a particular conclusion.
- RDs document and communicate nutrition-related information. The physician considers the nutrition information and makes the medical diagnosis independently.
- The recognition process is the work flow that assure that the physician has access to and views the dietitians report, and considers the information.

"Facility won't let me document malnutrition"

Medicare Conditions of Participation for Hospitals

..all medical records must include results of all consultative evaluations and appropriate findings by clinical and other staff.

CMS Hospital Survey Protocol:

§ 482.24(c)(2)(iii) *Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.*

See more detailed wording in *Notes* at end of slide set

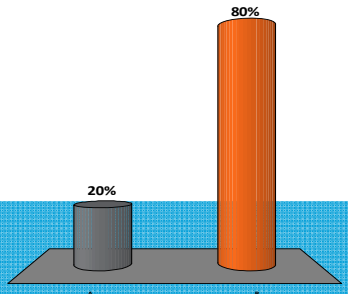
Source: 42 C.F.R. § 482.24(c)(2)(iii).Accessed 4/1/2012
Source: CMS State Operations Manual, Hospital Survey Protocol, Appendix A, A-0236. Accessed 4/1/2012

QUESTION: ICD-9 Classification Codes Will Not Change with Transition to ICD-10

A. True
B. False

QUESTION: ICD-9 Classification Codes Will Not Change with Transition to ICD-10

A. True
B. False



"What is ICD-10?"
"How does it connect with ICD-9?"

- ICD-9 over 30 years old
- Classifies diseases & other health problems recorded on various health records such as death certificates & other health records
- ICD-10 started in 1994
- Delayed in USA until October 1, 2014
- Changing 4000 codes to 68,000 codes
- Procedure codes change from 13,000 to 87,000

2012 ICD-9-CM Physician Volumes 1 and 2. American Medical Association

http://www.who.int/classifications/icd/en/

"What about nutrition risk screening in ambulatory care?"

- Generally when warranted by the patients condition
- Check with your department and regulations governing your facility
- Generally with a new patient visit
- With advent of common electronic health records that track patients from various settings of care, significant potential to track nutrition characteristics

ACTIONS & FUTURE CONCEPTS

"What will improve patient care & outcomes?"

- Early identification and intervention of at-risk patients
- Routine reporting of compliance with admission screening standards
- Should "hospital acquired" or iatrogenic adult malnutrition be reported?
- Flagging of at-risk or malnourished patients for handoffs
- Flagging of Readmitted malnourished patients at 30-60-90 days
- Physicians make medical diagnosis of malnutrition when present
- RD make nutrition diagnosis of malnutrition when present

(See more detail in Notes at end of slide set)

OPPORTUNITIES IN NUTRITION INFORMATICS:

Promise of Interoperability
- Within/between health systems and sites of care

Screening/Assessment Parameters
- Improved, reliable, valid, performed and measured
- Move beyond macronutrients!

Standard Report-outs
- Patient population surveillance
- Economic impact of incidence
- Impact of early and timely identification and intervention
- Impact to disease progression
- Costs of care/avoiding costs of care
- Readmissions

QUESTION: In the United States, the prevalence of adult malnutrition in acute care:

A. Is known to be greater than in Canada
B. Is difficult to determine due to historic lack of standardization of characteristics, defined criterion and likely under reporting
C. Is very low, as it does not often appear in official population disease or death records
D. Is over reported now that patients tend to be obese

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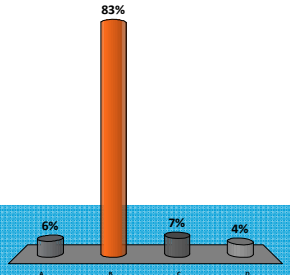


"What have others done about adult malnutrition?"

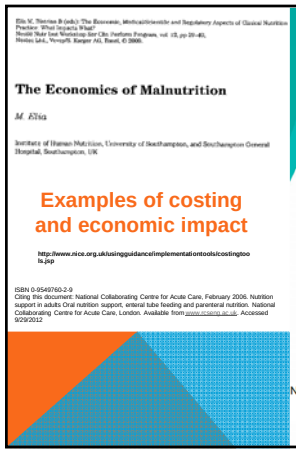
The European Nutrition for Health Alliance

ACCN ADRIATIC CLUB OF CLINICAL NUTRITION

INTERNATIONAL CONFERENCE ENDORSED BY NUPENS AND ACCN

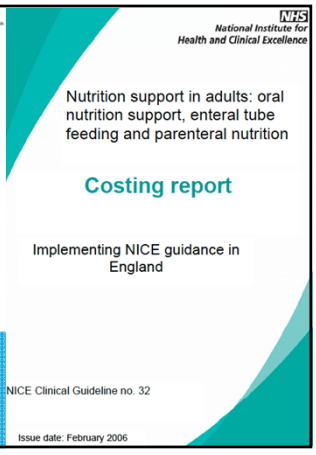
FIGHT AGAINST MALNUTRITION
TWO DECADES OF OPPORTUNITIES

Belgrade, April 22, 2012


The Economics of Malnutrition

M. Elia

Examples of costing and economic impact


NHS National Institute for Health and Clinical Excellence

Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition

Costing report

Implementing NICE guidance in England

NICE Clinical Guideline no. 32

Issue date: February 2006

CDC: 2010 U.S.A. discharged from hospital

45-64 years old	= 9,483,000 people
65 years +	= 13,591,000 people
… so, discharged 45+ years old	= 23,074,000 people

Literature reports: Malnutrition 25% to 35%, & Risk of malnutrition 30-55%

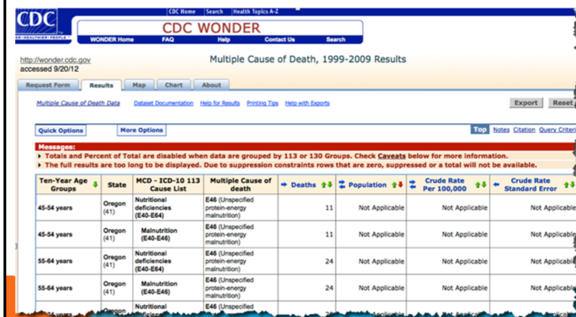
If this is true:

Malnourished (25-35%)	= 5.7 to 8.07 million people
Risk of malnutrition (30-55%)	= 6.9 to 12.6 million people

Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2010; US Dept of Health and Human Services, Centers for Disease Control and Prevention; National Center for Health Statistics. Series 10, Number 251 December 2011, Accessed 9/22/12

Int. J. Environ. Res. Public Health 2011, *8*, 514-527; doi:10.3390/ijerph8020514
International Journal of Environmental Research and Public Health ISSN 1660-4601 www.mdpi.com/journal/ijerph
Review Hospital Malnutrition: Prevalence, Identification and Impact on Patients and the Healthcare System
Lisa A. Barker 1,*, Belinda S. Gout 1 and Timothy C. Crowe 2

http://wonder.cdc.gov/controller/datarequest/D77;jsessionid=3B829DE350BBB311BA130439F106AA99#Citation

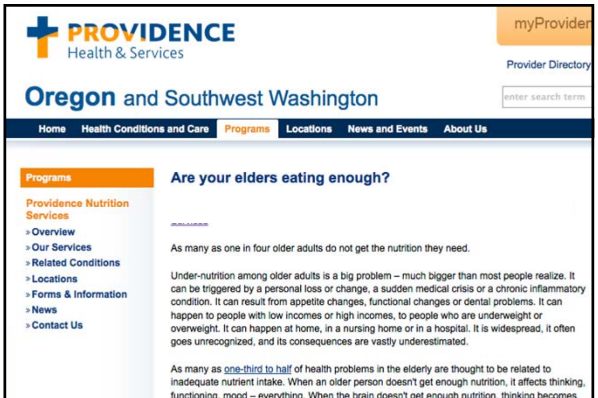

CDC
CDC Home
Search
Health Topics A-Z
CDC WONDER
WONDER Home
FAQ
Help
Contact Us
Search
http://wonder.cdc.gov
accessed 9/20/12
Multiple Cause of Death, 1999-2009 Results
Request Form
Results
Map
Chart
About
Multiple Cause of Death Data
Dataset Documentation
Help for Results
Printing Tips
Help with Exports
Export
Reset
Quick Options
More Options
Top
Notes
Citation
Messages:
Totals and Percent of Total are disabled when data are grouped by 113 or 130 Groups. Check Caveats below for more information.
The full results are too long to be displayed. Due to suppression constraints rows that are zero, suppressed or a total will not be available.

Ten-Year Age Groups	State	MCD - ICD-10 113 Cause List	Multiple Cause of death	Deaths	Population	Crude Rate Per 100,000	Crude Rate Standard Error
45-54 years	Oregon (41)	Nutritional deficiencies (E40-E64)	E46 (Unspecified protein-energy malnutrition)	11	Not Applicable	Not Applicable	Not Applicable
45-54 years	Oregon (41)	Malnutrition (E40-E46)	E46 (Unspecified protein-energy malnutrition)	11	Not Applicable	Not Applicable	Not Applicable
55-64 years	Oregon (41)	Nutritional deficiencies (E40-E64)	E46 (Unspecified protein-energy malnutrition)	24	Not Applicable	Not Applicable	Not Applicable
55-64 years	Oregon (41)	Malnutrition (E40-E46)	E46 (Unspecified protein-energy malnutrition)	24	Not Applicable	Not Applicable	Not Applicable

"How Do I Educate and Train?"

- Newsletters
- Display boards
- Website
- Nursing meetings
- Medical meetings
- Share with coders
- Share with documentation improvement specialists
- Share with decision support analysts
- Share with administrative leadership
- Consumers and patients!

Take every opportunity to educate about adult malnutrition


PROVIDENCE
Health & Services
myProvider
Provider Directory
Oregon and Southwest Washington
enter search term
Home
Health Conditions and Care
Programs
Locations
News and Events
About Us
Programs
Providence Nutrition Services
Overview
Our Services
Related Conditions
Locations
Forms & Information
News
Contact Us
Are your elders eating enough?
As many as one in four older adults do not get the nutrition they need.
Under-nutrition among older adults is a big problem – much bigger than most people realize. It can be triggered by a personal loss or change, a sudden medical crisis or a chronic inflammatory condition. It can result from appetite changes, functional changes or dental problems. It can happen to people with low incomes or high incomes, to people who are underweight or overweight. It can happen at home, in a nursing home or in a hospital. It is widespread, it often goes unrecognized, and its consequences are vastly underestimated.
As many as one-third to half of health problems in the elderly are thought to be related to inadequate nutrient intake. When an older person doesn't get enough nutrition, it affects thinking, functioning, mood – everything. When the brain doesn't get enough nutrition, thinking becomes

http://www.phsoregon.org/video/?view=d203426faaed7x480x293 (local TV spot)

"Why do we concern ourselves with malnutrition diagnosis only in hospital?"

… start earlier!

- MD offices
- Clinics
- Assisted living
- Other settings

… then maybe so much or severe won't arrive at the hospital?

Take Home Messages

- Screening and referrals needed in all settings of care early
  - Hospitals are only one location
- Refer at-risk and malnourished persons for nutrition assessment, counseling and education
- Document using Academy of Nutrition & Dietetics IDNT Nutrition Diagnosis of malnutrition ,and Academy/ASPEN Consensus Characteristics
- Physicians diagnose, treat, refer to RDs and document adult malnutrition
- Assure processes in place to capture and report adult malnutrition (Academy webinar 5/23/12)
- Educate the public and colleagues for awareness and prevention