Achievements in Improving Documentation to Depict a More Accurate Clinical Representation of Patients with Malnutrition While Increasing Visibility of the RDN

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Purpose: The purpose of this quality project was to improve the documentation of malnutrition diagnoses in the electronic health record (EHR) to represent more accurate depictions of patients’ clinical conditions.

Relevance: It is imperative to identify, prevent, and treat hospital malnutrition in order to provide high quality care for patients. Malnutrition diagnoses are often missed and are commonly queried by coders. Compared to those who are not, malnourished patients are more likely to have adverse outcomes such as: pressure injuries, falls, and delayed healing leading to longer stays and readmissions. Registered dietitian nutritionists (RDNs) are the experts who can provide low-risk, cost-effective interventions and engage the care team in efforts to provide high quality care for these patients.

Background: Work began at Spectrum Health (SH) in 2015 with a pilot study aimed at improving physician malnutrition diagnosis and documentation. RDNs worked with physicians to improve the process of documenting malnutrition. In January 2016, using the Malnutrition Quality Improvement Initiative (MQii) Toolkit, an executive-sponsored Malnutrition Steering Committee was initiated. The initial goal was to further improve the documentation of malnutrition diagnoses by RDNs and physicians. This required raising awareness around hospital malnutrition and the critical role of RDNs. It also required improving RDN performance of the Nutrition Focused Physical Exam (NPPE). In November 2017, enhancements were implemented to malnutrition documentation while switching EHR software platforms.

Methods: RDNs collaborated with informatics specialists, providers, coders, and analysts to improve documentation processes. Malnutrition specific flowsheet rows and a malnutrition note were added to the EHR. The RDN completes the flowsheet rows in the Nutrition Assessment Flowsheet to efficiently and completely document the criteria that supports a malnutrition diagnosis found upon assessment and physical exam. These are then pulled into a Malnutrition Note that is routed to the physician for cosign. This provider signature is required for coding malnutrition diagnoses. RDNs were also granted privileges to add malnutrition diagnoses to the Problem List. Concurrently, RDNs were further trained on the NPPE and raised awareness of expertise. The number of documented cases by RDNs and providers in 2018 were compared to the number in 2016 to determine the impact of these changes.

Results / Outcomes: The number of documented malnutrition cases by RDNs in 2018 was 3895, up 270% from 2016 (1440). Enhancing RDN NPPE skills improved identification and documentation of malnutrition.

The number of documented malnutrition cases by providers in 2018 was 1594 (Jan-May 2018), which was 7.2% of discharged patients in that time. This was up 23% from 2016 (667 between Jan-May 2016). Awareness efforts and EHR enhancements improved provider agreement with RDN diagnoses.

RDNs began adding malnutrition diagnoses to the Problem List in the EHR in November 2017. RDNs are the only disciple other than providers granted these privileges at SH. This allows the malnutrition diagnosis to be addressed at each health care encounter.

Conclusions: Improved documentation to represent a more accurate depiction of the clinical condition of patients with malnutrition was achieved. RDNs built interdisciplinary relationships while collaborating with other departments, which have elevated the RDN role in care and in decision making throughout the organization.

Implications for Policy or Practice: This work positioned RDNs to contribute to organizational policies that will help further improve the identification, prevention and treatment of malnutrition. To further support this, work is being done to begin to collect electronic clinical quality measure (eCQM) data on malnutrition-focused care practices and outcomes as part of MQii participation.

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RDN Audits to Determine the Prevalence of Hospital Malnutrition Reveal a Need to Shift the Focus of Quality Improvement Efforts

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Purpose: To identify areas of improvement in the care of malnourished patients, registered dietitian nutritionists (RDNs) evaluated the prevalence of malnutrition in acute care hospitals to inform processes for identifying malnourished patients and intervene with nutrition care plans.

Relevance: The literature suggests that 30-60% of patients are malnourished upon hospital admission and that 66% of those will experience further decline in nutritional status during their hospital stay. Early identification of malnutrition risk allows for prevention or intervention implementation to minimize adverse effects and improve outcomes.

Background: Since the publication of the Academy of Nutrition and Dietetics/ American Society for Parenteral and Enteral Nutrition (Academy/ASPEN) Consensus Statement on malnutrition, RDNs have expanded their practice and incorporated new skills in identifying hospital malnutrition. The process of identification, prevention, and intervention for malnutrition requires collaboration among the health care team. It is helpful to understand which processes are contributing to these efforts and which could be improved for higher quality care.

Methods: The malnutrition prevalence study was conducted on March 27, 2018. RDNs assessed 618 adult inpatients (90% of census) and relevant data was obtained for 582 through the electronic health record (EHR) based on data points recommended in the Malnutrition Quality Improvement Initiative (MQii) Toolkit.

The study was expanded to include 7 regional hospitals in October 2018. RDNs assessed all inpatients each Wednesday in the month to achieve a sample size of 329.

Both studies excluded pregnant woman, patients under hospice care or comfort measures, and patients under the age of 18 years.

Results / Outcomes: Of the 582 patients assessed in March 2018, 122 patients met the criteria for malnutrition; a prevalence of 21%. Astonishingly, RDNs found 41 patients (34% of malnourished patients) who met criteria but did not have a nutrition consult order in place. RDNs were involved in the care of the other 79 (66%). The Malnutrition Screening Tool (MST) was completed 91% of the time. Provider documentation and RDN intervention occurred nearly 100% of the time.

The prevalence of malnutrition in the regional hospitals in October 2018 was 12.8% (42 patients). RDNs were not consulted for 55% of malnourished patients. The MST was completed 98% of the time.

Conclusions: The organization implemented a new EHR platform only months before this study. The results revealed a need to shift the focus of quality improvement efforts from increasing provider-RDN diagnosis congruity to nursing education. While the MST was completed for most patients, RDNs were not consulted in 34% and 55% of the malnutrition cases. Interpreting screening results and appropriately placing the nutrition consult were new concepts for nursing in the new EHR platform. Conversely, a Malnutrition Note, created in the new EHR, assisted with provider documentation of RDN-identified malnutrition. Finally, the 21% and 12.8% malnutrition prevalence rates lead to efforts to increase RDN malnutrition identification competence.

Implications for Policy or Practice: Other organizations should similarly evaluate the alignment between RDN-identified malnutrition and malnutrition risk identified by other clinicians. Use of the malnutrition electronic clinical quality measures (eCQMs) may further enhance hospitals ability to track and monitor the accuracy of screening, assessment, diagnosis, and intervention practices.

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