Malnutrition Documentation—Munson Medical Center

This poster will illustrate how using a multi-disciplinary approach led by CDI and included Nursing, Dietary, Information Systems, HIM and Physician Champions resulted in a change in practice which yielded in an increase in malnutrition documented as a secondary diagnosis for a net CMI increase of 0.27. Estimated total reimbursement impact of $2,740,224.

The initiative started when the facility was trailing behind similar hospitals when documenting malnutrition as a secondary diagnosis. In just 3 DRGs (major bowel; sepsis; complex PNA) there was a potential opportunity of nearly $300,000 specifically related to the secondary diagnosis capture of malnutrition when compared to similar hospitals. Combined with physician push-back to document malnutrition, a multi-disciplinary team was created and led by CDI that included members from Nursing, Dietary, Information Systems, HIM and Physician Champions. The objective of the collaborative was to 1. Develop a process to ensure Nutrition consults occur as clinically indicated. 2. Improve and enhance the documentation process so that clinicians have access to Dietician documentation supporting a malnutrition diagnosis. 3. Decrease the number of missed opportunities to include malnutrition codes for inpatients using the MS-DRG and APR-DRG systems and 4. To improve the awareness of malnutrition in hospitalized patients and the need for timely implementation of nutrition interventions.

Physicians were frustrated as they felt the diagnosis of malnutrition should come from Registered Dietitians (RD), and RDs were frustrated because they were not getting consulted and at risk for losing positions. We first sought out to develop a process to ensure Dietary consults occur as clinically indicated. This involved implementing a Malnutrition Screening tool completed by the bedside RN both on admission and re-evaluation occurring on hospital day seven. The screening tool asked three simple questions and auto-calculated a score based on response. A score of 2 or higher would send a consult automatically to the RD. We also implemented and auto-consult for any pressure ulcer identified as stage 2 or higher.

This process allowed for the RD to be consulted on appropriate patients and complete a full assessment. The assessment included a nutritional diagnosis complete with clinical indicators and recommended interventions per ASPEN reference guidelines. If the patient qualified for a diagnosis of malnutrition, the appropriate severity was also given by the RD. This documentation was then available to physicians in the EMR who were either able to document the condition themselves, or provided the opportunity for CDI to query the physician with the clinical indicators, nutritional diagnosis and recommended interventions as written in the Dietary Progress notes. Composing the documentation query in this manor yielded an improved response & agreement rate and served as a physician satisfier which accounted for a recoup in net CMI increase of 0.27 for an estimated total reimbursement impact of $2,740,224 over nine months.

Alyson Swinehart, BSN RN CCDS
Clinical Documentation Integrity Coordinator-Coding & Data Integrity Services
Munson Medical Center, 1105 Sixth St. Traverse City, MI 49684
231-392-0331 aswinehart@mhc.net