Improving documentation and coding of malnutrition – a five year journey

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Background
Protein-energy malnutrition (PEM) is common (30-50%) in hospitals throughout Australia and negatively impacts on morbidity, mortality, length of stay, and healthcare costs. Documentation and clinical coding of PEM can in some cases increase the complexity and comorbidity level for some patient admissions, changing the Diagnosis Related Group (DRG) and increasing the case-mix funding to hospitals.

Methods
A pilot study at St Vincent's Hospital Melbourne conducted over a five week period in 2011 found the failure to diagnose and document malnutrition on the gastroenterology unit resulted in 6% ($21,500) loss of potential weighted inlier equivalent separation (WIES) funding. The local Nutrition Committee has led a number of improvement initiatives, including establishing malnutrition risk screening processes, developing PEM diagnosis and documentation guidelines, using malnutrition diagnosis stickers in the medical record, and adding a malnutrition diagnosis prompt on the electronic medical discharge summary.

Results
Overall, documentation and clinical coding of PEM for patients staying for three or more days has increased from 0.9% in 2010 to 7.8% in 2014. Specifically, documentation on higher risk units has improved over the past four years, such as in geriatric medicine (2.4% to 18.5%), oncology (1.2% to 25%) and gastroenterology (2.0% to 25.1%).

Discussion
Liaison with clinical champions and coding staff to build and maintain working relationships has assisted in these improvements. Prevalence of coded PEM is now included as a monthly indicator on the Medical Head of Unit report to increase awareness within each treating unit and track performance. The potential loss of WIES funding has been an important driver to support a number of hospital wide initiatives and ongoing work is exploring how these are supporting and translating to improvements in nutrition care and clinical outcomes for patients.