Presentation Title: The State of U.S. Healthcare Financing

Disclosures
  - “I have no commercial relationships to disclose”

Presentation Overview/Summary
The presentation will serve as the cornerstone for 3 subsequent ones. Two are designed to educate ASPEN members about ASPEN’s Value Project. The last one will demonstrate the pivotal role appropriate documentation of nutrition related diagnosis and intervention play in demonstrating the value of nutrition care.

The introductory presentation will review the history of the U.S. healthcare financing leading to the present Value-Based Care system which currently is devoid of required nutrition measures. ASPEN members will be urged to become involved at their local level with the provided information to make the case for the value of nutrition at the local level.

Learning Objectives:
At the conclusion of the presentation, the learner should be able to:
1. List 3 major changes in US Healthcare financing over the past century
2. Name 3 factors which have led to the current healthcare financing system
3. Outline major differences between “Volume” and “Value” financing

Key Takeaways/Fast Facts
1. Despite a plethora of healthcare financing systems over several years, increasing costs without concomitant improvement in quality safety, safety and access has resulted in significant paradigm shifts. One of these has been the shift from volume to value.
2. In order to not only survive, but also thrive in the current environment ASPEN has expanded its mission of providing specialty nutrition services to clearly articulate the value proposition for nutrition support across the continuum of healthcare delivery.
3. Inasmuch as the majority of the measures required for optimal reimbursement it is incumbent on ASPEN members to be actively involved at various levels, but particularly locally as ambassadors of appropriate and optimal nutrition care.
4. The Value Project is designed with the goal of providing evidence-based medicine in order to enhance the ASPEN members armamentarium.

Learning Assessment Questions
1. Question 1: The U.S. % of Gross Domestic Product (GDP) expenditures for healthcare for the years 2016-2018 has been approximately
   A. 20%
   B. 18%
   C. 15%
   D. 10%
2. Question 2: As was the case in 1983 with the enactment of Inpatient Prospective Payment System (including DRGs) physicians and some allied health professionals are not impacted by Value-based quality measures and reimbursement
A. True
B. False

3. Question 3: The following conditions can be positively impacted by appropriate nutrition care
   A. Surgical Site Infections (SSI)
   B. Pressure Sores
   C. Sepsis
   D. Mechanical Ventilation
   E. All of the above

4. Question 4: The Social Security Act of 1935 initially provided coverage for healthcare for the elderly
   A. True
   B. False

5. Question 5: Compared to developed countries, the US leads in % of the following EXCEPT:
   A. Life expectancy
   B. % GDP
   C. Length of Stay
   D. Maternal mortality
   E. Life Expectancy

Learning Assessment Answers:
1. Answer =B 18.296 in 2018
2. Answer = B False MACRA (MIPS & APMS)
3. Answer = E Variety fo articles in the literature
4. Answer = B False
5. Answer = C Other countries have higher LOS; Rationale: Explain answer

References
10. The Hospital Value-Based Purchasing Program. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html
The State of US Healthcare Financing-Summary
Albert Barrocas, MD, FACS, FASPEN

Why should ASPEN members be concerned with healthcare financing?
Because, “if you are not at the table, chances are that you will be on the menu”

Concerns regarding healthcare financing, quality, cost and change date back to ancient times. Heraclitus (535-475 B.C.E.) “The Obscure”; “the Weeping” Greek philosopher stated:
“Doctors cut and burn and torture their patients, and then demand a payment”, and,
“Change is the only constant in life”

Changes, often described as “convulsive”, have been experienced in the healthcare environment since that time and US since 1798. Some of the major transformations include:

- Innovations in Medicine, Surgery and Technology (including computerization)
- Increased survival of previous fatal illnesses and increased life expectancy
- Urbanization
- Healthcare financing and reimbursement varied programs

In turn, these changes have led, in part, to:

- Erosion of the direct physician-patient relation and bedside care at home, now delivered in hospitals and other healthcare facilities by a multidisciplinary team
- Emphasis on rescue and repair care from lessons learned through various wars
- Economic population disparities
- Inability of government payers, employers, health plans and private consumers to sustain the rising costs and inefficiencies of healthcare delivery

As a result of these and other “convulsions” over time, US healthcare financing has and continues to have many challenges including:

- Cost
- Quality and Safety
- Access
- Population health,

managed and to a great degree controlled by legislators, regulators and administrators exhibiting the health care version of “The Golden Rule” → “Whoever has the gold, makes the rule”. 
Despite having one, if not the best, healthcare technology and resources in the world, the costs and quality outcomes of the U.S. rank lower than other developed nations. US healthcare costs in 2018 accounted for 18.26% of Gross Domestic Product (GDP) compared to the second highest country, Switzerland 12.2 (2017). The per capita expenditures for 2017 for the two countries were $10,224 and $8,009 respectively with the UK demonstrating the lowest at $4,246. The US mortality, including maternal, rates and disease burdens are the highest among the 11 developed countries. Lower limb amputations related to diabetes and medication errors are higher in the US when compared to other countries.

The etiology of the rising cost of US Healthcare is multifactorial allegedly including:

- Aging population with multiple co-morbidities
- Diminishing number of those able to contribute healthcare financing due to retiring baby boomers
- Rising medication costs and information overload for patients (not always accurate)
- Changing/Advancing Technology
- Rising administrative and other costs
- Liability Premium costs and concerns leading to defensive medical care
- Over testing
- Lack of coordination of care (Silo care)
- Inadequate end of life planning and “Crucial/Critical Conversations”
- Inefficiencies/Ineffectiveness
- Burnout physicians, nurses and clinicians
- Lack of standardization of certain protocols, guidelines, Evidence Base Medicine
- Role of patients: Sometimes passive other times demanding; from patient to consumer

The payer stakeholders, regardless of the specific contributing factors listed above, realized that continuing a reimbursement system based on fee-for-service without linkage to outcomes and incentivizing quantity was unsustainable. Over the past decade, in response to the expressed concerns we have seen acceleration of several paradigms shifts such as:

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<td>Volume</td>
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<td>Fee -for-Service</td>
<td>Fee for Value-OWAs (Other Weird Arrangements)</td>
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<td>Direct Episodic Payment</td>
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<td>Process (Compliance) Metrics</td>
<td>Outcome Metrics</td>
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<td>Physician Centric</td>
<td>Patient/family centric (Engagement)</td>
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<td>Silos Care</td>
<td>Integrated, across continuum Care</td>
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<td>Solo Practice</td>
<td>Group/Employment</td>
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<td>Rescue and Repair (Acute Care)</td>
<td>Disease Prevention/Health Promotion (Chronic Care)</td>
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<td>Patient focus</td>
<td>Population focus</td>
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Two federal legislative Acts have influenced most of the metamorphosis toward Value-Based Care (VBC):

1. The Affordable Care Act (ACA) of 2010 dealing with healthcare institutions
2. The Medicare Access and CHIP (Children’s Health Insurance Programs) Reauthorization Act (MACRA) of 2015 composed of:
   a. The Merit-Based Incentive Payment System (MIPS)
   b. The Advanced Alternative Payment Models (APM)

affecting “eligible clinicians”, a group which was expanded in 2019 to include Physical and Occupational Therapists, Clinical Psychologists, Qualified speech-language pathologists, Qualified audiologists and Registered dietitians or nutrition professionals.

More detailed information regarding the implementation of the legislations can be found in:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

Basic to the demonstration of the value of nutrition in the current environment is a clear definition of value. Simply stated Value is Quality and Outcomes at the least Cost or “The biggest Bang for the Buck”
Instead of rewarding volume, new value-based program payment models reward results in terms of cost, quality and outcome measures. To date none of the value-based care programs for hospitals and clinicians incorporate a specific nutrition-related outcome measure, though nutrition care impacts multiple quality measures. Examples in MIPS include:

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<th>Diabetes: Hbg A1c Poor control-001</th>
<th>Weight Assessment &amp; Counseling Peds-239</th>
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<td>BMI-128</td>
<td>Surgical Site infections-357</td>
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<td>Readmissions-356, 358</td>
<td>Prevention of CVC RB Infections-076</td>
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<td>Nutrition Screening-(IA_AHE_3)</td>
<td>Falls Risk Assessment-154</td>
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In the realm of Hospital Based Programs {{Value-Based Purchasing, Hospital Associated Conditions (HACS) and Hospital Associate Infections (HAI)}} Examples include:

- Readmissions
- Mortality
- Infections
- Falls
- Pressure Ulcers
- Specific co-morbidities

The Board of Directors of ASPEN recognized the importance of the changing healthcare financing and reimbursement environment impacting the society members a few years ago. To that end the BOD established the Value Project Council which I have the privilege of Co-Chairing with Renay Tyler and with the wise counsel of Peggi Guenter from ASPEN Staff. The goal of the Value Project is to identify evidence-based data (directly or indirectly) that demonstrates the value of nutrition from a cost perspective. The expectation is that the results will provide ASPEN members with the appropriate data, talking points and appropriate language to effectively and efficiently communicate with administrators, regulators and legislators in their own environments acting as ambassadors for Value-based nutrition care. The Value Project progress and strategies will be discussed in the two subsequent presentations followed by a presentation highlighting the importance of appropriate diagnosis and documentation.

In sum, the effort by ASPEN’s BOD and the Value Project Council is projected to allow you to “Be at the table and not on the menu”

Additional statistical and comparative data may be found at:

https://www.healthsystemtracker.org/chart-collection/health-healthcare-system-overview/?_sf_s=of+the+healthcare#item-average-wealthy-countries-spend-half-much-per-person-health-u-s-spends-hohs_vid


Additional historical perspectives and specifics of the current US healthcare financing and reimbursement will be provided during the live presentation during the 2019 Conference.
REFERENCES


24. Hospital Readmissions Reduction Program (HRRP) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.html


27. Maryland’s Total Cost of Care Model Background and Summary https://hsrc.state.md.us/Documents/Modernization/TCOC%20Background%20and%20Summary%20_5_23_18%20.pdf


36. Health System Dashboard. Health system Tracker-Peterson-Kaiser


38. Hospital-Specific Reports Tutorial Video https://youtu.be/0pE6VBUE8c8

Demonstrating the Value of Nutrition

The State of Healthcare Financing

Albert Barrocas, MD, FACS, FASPEN
Chief Medical Officer (Ret.)
Atlanta Medical Center
Moderator
March 24, 2019

"If you are not at the table, you may be on the menu"

Welcome to our on-site, virtual and international audience

Before We Begin…

No

- Phones, Cameras, Empty seats in center front
- Lengthy introductions, Spectator sport

Yes

- Ask questions & offer your experiences briefly during Q&A at end of presentation
- Evaluations and claiming of CE credit are done online/CE Pavilion
- Session recordings and handouts will be available after the conference in A.S.P.E.N.’s eLearning Center.
- Full conference attendees receive complimentary access to all available conference session recordings, slides and handouts made available by the faculty.
- Refer to the on-site program book for details.
- Remove personal belongings from chairs

Disclosures and Objectives

- Disclosures
  - I have no commercial relationships relevant to the topic being presented
  - I am not a healthcare economist, regulator or legislator

- Objectives*: At the conclusion of the presentation the participant should be able to:
  - List 3 major changes in US Healthcare financing over the past century
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*Also Learning Assessment Questions

The Why?

If you are not at the table, you may be on the menu

Your Choice

Remember that there is no “success” without “U”

Doctors cut and burn and torture their patients, and then demand a payment

"The only thing that is constant is change"("Change is the only constant in life.")

Heraclitus (On Nature)

““The obscure”, “the weeping” Greek philosopher

Historical Perspective - US Health Care: Then and Now

1891 2019
Health care in transition: the Physician and the OWAs

Health care delivery in the United States is in a state of transition. The busy physician is unable to keep abreast of the complex changes in the health care system ranging from new technology to reimbursement issues. The competitive marketplace of the emerging health care business has brought new challenges to the dedicated physician who must not only concern himself with the pursuit of clinical endeavors but also with the evolution of such phenomena as PPOs, HMOs, and OWAs (Other Weird Arrangements).

U.S. Healthcare Financing Timeline

- **1798**: Marine Service Hospital
  - Social Security Act: Assistance for maintenance of needy children, dependent children, etc.
  - The "Blues" (Blue Cross - Blue Shield, 1939-1946, Blue Cross Blue Shield Association)

- **1935**: Medicare & Medicaid
  - HMO Act: Expecting to help the elderly in state management of health care
  - Medicare/Medicaid

- **1939 & 1946**: IPMS
  - The "Blues" (1939-1946, Blue Cross Blue Shield Association)

- **1946**: IPMS
  - The "Blues" (1946-1982, Blue Cross Blue Shield Association)

- **1965**: IPA
  - Health maintenance as one means to contain costs of healthcare

- **1982**: TEFRA
  - Cost containment vs. Coverage expansion

- **1983**: PPS-DRGs
  - From retrospective fee-for-service to prospective payment system

- **1990**: OBRA
  - Medicare Advantage

- **1993**: HIPAA
  - Comprehensive U.S. health insurance reforms

- **1997**: BBA
  - Medicare Advantage

- **2010-2019**: ACA (Obamacare)
  - Multiple challenges

US Healthcare Hurdles

- **Cost**
- **Quality**
- **Access**
- **Changing/Advancing Technology**
- **Increasing elderly Population**
- **Increased Life Expectancy and # of Comorbidities**

U.S. National Health Expenditure as percent of GDP

- **2018**: 18.296%
- **1960**: 5.96%
The U.S. has the shortest life expectancy among comparable countries 2017 → 78.6 years

Maternal Mortality Rate is Highest in US

US Elderly Sicker and Have Greater Difficulty Affording Healthcare Than Those in Peer Nations

Paradigm… SHIFT HAPPENS!

Delivering “Value”

CMS’ Original Value-Based Programs

End-Stage Renal Disease Incentive Program (ESRD QIP)
Hospital Value-Based Purchasing (HVBP) Program
Hospital Readmission Reduction (HRR) Program
Physician Value-Based Modifier (PVBM) Program
Hospital Acquired Conditions (HAC) Reduction Program
Other HVBP-Plus Programs

1. Patient outcomes include survival or improvement in symptoms of patients with diabetes, heart failure, and pneumonia.
2. Cost is multifactorial, including time, effort, emotions, and dollars.
Maryland (only State)
Waiver >40yrs all payer system
2014→Fee-for-feet to annual fixed global budget

August 15, 2016
Maryland Hospital Association Wins Davidson Award for Pioneering Efforts on Value
Institutions across state involved in all payer system, global budgeting

Private insurers, individuals, Medicare/Medicaid
Pay same amount for same service at same hospital
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Hospitals funding at risk based on performance
Each hospital held financially accountable for the performance of all

VALUE-BASED PROGRAMS

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The Road to Value-Based Care: CMS Mandatory Program Timeline (With Performance Risk)

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The Faculty Stars

- Peggi Guenter, PhD, RN, FAAN, FASPN
  Sr. Director of Clinical Practice, Quality, and Advocacy
  American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.)
  The ASPEN Value Project: Task 1 – The Literature
  “In order to be understood, you must first understand”

- Renay Tyler, DNP, RN
  Vice President for Ambulatory Services
  University of Maryland Medical Center
  The ASPEN Value Project: Task 2: The Medicare Claims Data Analysis
  “Demonstrating the value of nutrition depends on accurate and specific data”

- Cindy Hamilton, MS, RD, LD, FAND
  Senior Director of Nutrition | Center for Human Nutrition | Digestive Disease and Surgery Institute | Cleveland Clinic
  Optimizing value through Standardized Malnutrition Diagnosis and Documentation
  “Appropriate documentation at the bedside—where the rubber meets the road!”
The ASPEN Value Project: Background and Proposal

Peggi Guenter, PhD, RN, FAAN, FASPEN

1. Background
2. Goals
3. Means
4. Methodology
   A. Part 1 Literature Review
   B. Part 2 Medicare Claims Data Analysis
   C. Part 3 Communication Plan
Name: Cindy Hamilton, MS, RD, LD, FAND  
Title: Sr. Director, Center for Human Nutrition  
Affiliation: Cleveland Clinic, Cleveland, Ohio

Presentation Title: Optimizing Value Through Standardized Malnutrition Diagnosis and Documentation

Disclosures:  
- I have no commercial relationships to disclose

Presentation Overview/Summary
This presentation will show how malnutrition programs bring value to patient care through documentation and how it can affect hospital quality measures such as the Severity of Injury Score, Risk of Mortality Score and the Case Mix Index. Various documentation tools such as the hospital Problem List and Problem Oriented Charting can further enhance malnutrition documentation. Other value-add nutrition programs such as group or shared nutrition appointments, virtual appointments and strategic booking will be presented.

Learning Objectives
At the conclusion of the presentation, the learner will be able to:

1. Outline value opportunities for standardized malnutrition diagnosis and documentation.  
2. Discuss value-add nutrition programs and initiatives.

Key Takeaways/Fast Facts
- Use a multi-disciplinary approach to malnutrition documentation programs which are supported by institution decision-makers  
- Specificity of malnutrition documentation can shift the DRG, increasing the SOI, ROM, CMI and result in proper payment  
- Tools to enhance malnutrition documentation may include: evidence-based screening, problem list, problem-oriented charting  
- Nutrition value added programs include SMA, SNA, Virtual appointments, strategic booking

Learning Assessment Questions
- 1. True or False. A malnutrition diagnosis can impact the DRG assignment, Severity of Injury (SOI) and Risk of Mortality (ROM) score.  
- 2. True or False. The Problem List and Problem-Oriented Charting are potential electronic health record tools used for capturing a malnutrition diagnosis.  
- 3. Examples of nutrition value-add programs include all EXCEPT:
  A. Virtual Visits  
  B. Group Visits  
  C. Strategic Under-booking
Learning Assessment Answers:

1. True. Malnutrition, as a secondary diagnosis can shift the weight of the DRG, SOI and ROM to reflect the complexity of the patient.

2. True. These tools, if available in the EHR, can provide communication and clarity of a malnutrition diagnosis and support accurate documentation.

3. C. Strategic Under-booking. Strategic Over-booking can improve access to patient care and account for high no-show or cancellations.
Optimizing Value through Standardized Malnutrition Diagnosis and Documentation

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Sr. Director
Center for Human Nutrition
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• Outline value opportunities for standardized malnutrition diagnosis and documentation
• Discuss value-based nutrition programs and initiatives

Health Care Reform

• Major US Health Policy Change - The Affordable Health Care Act
  - 2012
  - AIMS
    o Access - available to citizens, individual/employer plans; Medicaid expansion
    o Quality - improve - pay for performance, value-based purchasing, alignment of incentives
    o Cost - decrease and be more efficient
  - Transparency
  - Linking cost and quality to reward
  - ACOs, shared savings, VBPs

Value Based Purchasing

Value = Outcome ÷ Cost

The CMS to link Medicare’s payment system to a value-based system:
• Value based payment (pay 4 performance)
• Hospitals payed based on the quality of care, not just quantity
• Financial incentives for meeting performance measures; penalties for poor outcomes and increased costs
  o Lowering blood pressure
  o Counseling patients to stop smoking
  o Hospital readmission penalties (<30 d)
  o Hospital acquired conditions (pressure ulcers)
  o Improved safety; metrics (i.e. falls, needle punctures)

Does Value-Based Purchasing really apply to Nutrition?
What can Nutrition Clinicians do?

Value-based care
Outcome
Safety
Efficiency
Costs
Revenue
Care coordination
Continuum of care

“ALL nutrition clinicians need to engage in healthcare reform initiatives or risk becoming an undervalued service provider.”
Elements of Nutrition Value Propositions

- Require a multidisciplinary approach, consider all stakeholders
- Require a champion - physician, hospital executive
- Demonstrate a financial impact
- Demonstrate improved clinical outcomes
- Align with Institution priorities

Variance in Two Languages: Bridge the Gap

- Physician Documentation is received in CLINICAL terms
- Documentation for coding, profiling & compliance requires specificity in DIAGNOSIS terms

Why Good Documentation Matters

- Right thing for our patients to have complete and accurate medical records
  - Enhances communication between providers
- Assures accurate measures of quality, safety, and efficiency
  - Assures accountability and transparency
    - Captures the level of complexity, risk of mortality, and severity of the patient
- Supports proper payment
- Provides better business intelligence
- Supports clinical research

Benefits

- Improved quality of documentation may lead to an increase in
- CC/MCC Capture
- SOI/ROM
- CM

Malnutrition Documentation

- CC=Comorbid Conditions and Complications - Moderate PCM (E44)
- MCC=Major Comorbid Conditions and Complications - Severe PCM (E43)

Secondary Diagnoses

- New conditions occurring during the stay
- Chronic & acute pre-existing conditions prior to admission
- IMPACT the DRG assignment, SOI and ROM
**Assignment of Severity of Illness Subclass (SOI)**

APR DRGs are subdivided into SOI (All Patient Refined Diagnosis Related Groups)

- 4 severity levels
  - Minor
  - Moderate
  - Major
  - Extreme

SOI determined by:
- Interaction of multiple illnesses
- Involving multiple organ systems
- Difficult to treat
- Poor outcomes

**Factors that Influence Reimbursement**

- **ROM (Risk of Mortality)**
  - The risk of mortality (ROM) provides a medical classification to estimate the likelihood of in-hospital death for a patient. The ROM class is used for the evaluation of patient mortality.
  - 4 severity levels:
    - Minor
    - Moderate
    - Major
    - Extreme

- **CMI (Case Mix Index)**
  - Case mix index (CMI) is a relative value assigned to a diagnosis-related group of patients in a medical care environment.
  - The CMI value is used in determining the allocation of resources to care for and/or treat the patients in the group.

**Improved Nutrition Documentation Difference**

**Malnutrition DRG Project: Documentation Integrity**

- **Quality Impact**
  - Encounters with Malnutrition Query
    - Prevalence: ↑ 1.1% (8.9-10%) 1600 pts
    - SOI: ↑ 0.11 high volume DRGs
      - ↑ 0.08 all DRGs
    - ROM: ↑ 0.06 high volume DRGs
      - ↑ 0.10 all DRGs
    - 11% of queries led to substantial increase in net revenue

**Assessing for Missed Opportunities**

- Nov 2013 - April 2014
- # of Nutrition Cases N=2442
  - Positive difference: 91%
  - No difference: 9%
  - # of Nutrition Cases N=2348

**Key Goals**
- Improve nutrition screening
- Standardize/document malnutrition by RDs
- Increase in provider documentation of malnutrition
- Increase use of malnutrition as secondary billing diagnosis
- Improve patient care
Standardizing a Validated Nutrition Screening Tool (Malnutrition Screening Tool-MST)

- Replace current screening tool with validated tool across the health system (MC, 8 regional, 1 affiliate, FL)
- Create auto EHR system list to alleviate need for RN to place Nutrition Consult
- Nursing Communication/Development Stages:
  - approval from various nurse leaders
  - work with nursing informatics to build in EHR
  - work with nursing education on communication tool
- Quality/Compliance metric

Nutrition Screening: Discipline-Based Results

Methods:
- Randomly selected patients (N=109) from variety of inpatient medical and surgical nursing units
- Nutrition screening performed: RN (part of Nursing Admission Assessment) and by RD
- Captured: Percent of patients with a positive nutrition screen

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Percent of Patients At Risk for Malnutrition Based on Discipline Performing Nutrition Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>42%</td>
</tr>
<tr>
<td>RD</td>
<td>37.8</td>
</tr>
</tbody>
</table>

Dietitian Consults Not Ordered (CNO) When Identified At-Risk (6/2015)

- N=351
- 40% Not ordered
- N=221
- 60% Ordered

Data collection: 14 days
- CNO/day: 14-25
- RD average consults/day: 8
- Dietitians: 3

Value of Standardized/Validated Screening Tool

- Improved capture of patients at risk
- Improved referrals to RDs for assessment
- Requires a reliable, 'easy' electronic tool

Note: Not all patients can be screened
- Building secondary screen for those pts who can't answer MST (BMI<20, recent PCM dx in 3 months, adm dx of FTT, wt loss or malnutrition)

Standardization of Dietitian Practices for Diagnosing and Documenting Malnutrition

- Train and implement ASPEN/AND characteristics*
- Train NFPE
- Standardize documentation process (EHR)
- Develop sustainable training process
- Establish quality metrics


Chronological Timeline

- April 2016: RDs add to PL
- August 2016: Capture: 7.7%; 2014, 9.8%; 2016, 15%
- October 2016: Standardize Nursing Admission Screening - MST
- March 2011: Center for Human Nutrition develops Malnutrition Task Force
- October 2012 - May 2013: Trained CCHS RDs (98) to guidelines; standardized RD documentation templates
- EPSI ICD-9 Malnutrition codes for CCHS indicate capture of 6.1% in 2012, 6.9% in 2013
- August 2013 - January 2014: CCHS RDs meet with 47 MD groups to present malnutrition dx and documentation
- September 2013: Standardized CCHS nursing nutrition admission screening questions
- April 2014: Integration with DRG Assurance
- May 2014: Two pilot studies RN screen capture
- October 2014: Epic CDI Work List Pilot
- January 2015: Cindy Assumes Enterprise Scope
- March 2015: CDI Work List Go-Live Main Campus and Hillcrest
Problem List-EMR

- Specifies new, active, and chronic medical conditions
- Identifies important factors for coordination of care
- Acts as foundation for problem-oriented note templates

Adding a Malnutrition Diagnosis as a New Problem

A malnutrition diagnosis will now appear under hospital problems list.

RESULTS: DIETITIANS ADD MALNUTRITION TO PROBLEM LIST

CCHS Malnutrition Diagnosis Rate

What Else can Improve Malnutrition Documentation?

Problem-Oriented Charting (aka: Problem-Based Charting)

- Problem-oriented charting is a form of medical documentation that organizes patient data by a diagnosis or problem.
- Problem-oriented charting provides opportunity for innovation through patient data retrieval tools and problem-oriented templates.

Problem List Populates Documentation Template
**Value of Problem-Oriented Charting**

- Co-morbid Condition/Complication (CC) and Major CC capture
- Improvement in Severity of Injury (SOI)
- Improvement in Risk of Mortality (ROM)
- Improvement in Case Mix Index (CMI)
- Improvement in risk adjusted Length of Stay (LOS)
- Financial gain

**DDSI Institute- Case Mix Index**

![Chart showing Case Mix Index over time](chart)

**CC/MCC Capture and Financial Impact of POC**

![Chart comparing CC/MCC Capture and Financial Impact between Aug-Dec 2017 and Aug- Dec 2018 with POC](chart)

**Other Examples- Nutrition Value-Based Purchasing**

- Group education classes, Shared Medical Appointments (SMA) or Shared Nutrition Appointments (SNA)
- Virtual Visits
- Strategic Booking
- ERAS

**Heart Failure- 30 Day Readmission Rates**

![Graph showing Heart Failure 30 Day Readmission Rates](chart)

* Electronic checklist implemented 10/2014
  Goal: 20%

**Virtual Visits**

![Graph showing Virtual Visit Volume](chart)

Digestive Disease Institute Virtual Visit Volume
Jan 2018 - Jan 2019

- General Surgery
- Gastroenterology and Hepatology
- Colorectal Surgery
- General Surgery
- Digestive Diseases Institute
**Strategic Booking – Creating Value with Access**

- Strategically overbooking clinic slots to account for no-shows or cancellations.
- The goal is to see the number of patients on the original template.

**Outpatient Nutrition Appointments:**
- 28-30% Cancellation/No Show Rate
- Established number of patients to be seen per ½ day: 5 and pts per hr: 0.9
- Determine best time of day to establish double slot

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**Summary**

- Use multi-disciplinary approach to malnutrition documentation programs supported by institution decision-makers
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**Answers**

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