**Nutrition and the EHR Webinar Question and Answer Session**
**Recorded on January 23, 2019**

Moderator: Dr. Vincent Vanek (responses in red below)
Speaker: Dr. Cassandra Kight (responses in blue below)

Question from Mary Russell: The Academy/ASPEN consensus recommendations for malnutrition clinical characteristics are not validated-has this been a concern for you Dr Kight?
During the presentation I mentioned that as an organization, it should establish the malnutrition criteria that will be used by all employees. One example of malnutrition criteria that some organizations have adopted is the AND/ASPEN malnutrition criteria published in 2012 for adults and 2015 for pediatrics. The Academy/ASPEN are working on validating their malnutrition criteria but in the meantime, these criteria have been widely accepted and used by nutrition clinicians.

In regard to the guideline stating that TPN orders should reflect TPN label: what recommendations do you have for facilities that order in ions rather than salts?
The PN label should then show both the electrolyte ions and the salts. Also, should be able to build Clinical Decision Support to display ions and salts at the time of order entry.

What are latest trends/thoughts/science of 2:1 vs 3:1 for pediatric home PN. Lots of dialog and varying opinions between vendors.
Cannot comment on this as that was outside of the scope of the PN in EHR consensus recommendations and I do not have expertise in pediatric home PN to comment

Our hospital/health centre has neonatal and pediatric TPN with separate order parameters, and we have orders for TPN to be sent to/provided by outside pharmacy for outpatients. What are you recommendations for implementing orders and maintaining separation?
Neonatal and pediatric PN orders should have separate order parameters so should be built as 2 separate sets of PN orders in the EHR. In regards to transmitting inpatient PN orders to an out sourced pharmacy, ideally this should be accomplished with a direct interface between the inpatient EHR and the out sourced pharmacy EHR. However, few healthcare facilities have such interfaces in place today. The goal is to minimize any manual transcription from the PN order entered into the EHR by the provider and the automated compounding device (ACD).

During the implementation phase - wouldn't it make sense for that to be the time to explore all the "nice to haves" to determine what can be included?
It is important for nutrition clinicians to be involved in all phases of the EHR implementation including purchasing of the EHR, initial build of EHR, pre-go live training for EHR, and post go live optimization. It is also important for nutrition clinicians to be engaged with the local healthcare systems EHR build team as well as the EHR developers and analysts to ensure the appropriate clinical nutrition content is included in the EHR build and workflows. When a new EHR is implemented in a large organization, the first focus is on employees being able to perform their job, take care of patients, and ensure adequate documentation. The EHR bells and whistles may never be implemented, and if they are, require additional system build. That is why the "nice to have" things are often implemented in the second phase after go-live.

Is there a Evaluation and Management code or CPT codes for nutrition evaluation/interventions in hospital?
Current Procedural Terminology (**CPT**) is a medical **code** set that is used to report medical, surgical, and

diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.

CPT codes 97802 and 97803 are for Nutrition Counseling, but as you are probably aware, are used in the outpatient setting. I am not aware of their use in the inpatient setting, but I am not a billing expert. Perhaps someone who reads this will let us know if they are aware of its use, and let us know!

Can you explain "discrete manner"?
Discrete data is that which can be tracked over time because it was entered into a field type that is stored in one particular place in the patient medical record. Examples of how data is entered discretely is a number field for vital signs, weights, laboratory results. You can track those over time by date because when the data is stored, it is associated with the date of entry. Other discrete EHR elements are when you click a button or make an entry from a dropdown list. The choices for that button or dropdown list are predefined. Examples would be where you obtain MUAC – the right arm or the left arm. There are no other options to choose an arm. Discrete data can be reported over time, as mentioned, or displayed in a report because the report can be configured to pull the arm selection when you pull the MUAC value.

So if we are manually typing in a dx of Malnutrition under the "Comment" section in a PowerNote of Cerner, this is unable to be captured?  We should be "clicking" it off to be actually "discrete"?
If you are manually typing in the diagnosis of malnutrition in a note format, it is not discrete. You cannot retrieve that data for that patient or any other patient IF it is only captured in a note. For instance, if you went to your IS team and said I would like to know all the patients diagnosed with malnutrition in the last 6 months, they can't pull that data from the patient's chart. There is technology to read text in notes to determine this information, but it is challenging and not done unless they have to for some reason. If you want to know data, you have to enter it in a discrete manner which means you can pull a specific item out of the patient's medical record. Think of it as a hook. There has to be some reason for a data search to know to stop in that patient record to find that information.

If you are typing in the malnutrition diagnosis BUT you or a provider are adding malnutrition to the Problem List, that is a way to track it discretely because a data search can be find E43 or E44.1 in the patient's problem list and put them on this report.

for Cassie- Slide 41- under "communication" I wanted to know more about point #1- EHR alert- using decision support tools- you mentioned an alert button- can you explain how this works.
EHR vendors include decision support tools. It means if a certain parameter is met, the provider becomes aware through an alert when they go into the patient's chart. One such alert could be a blood pressure that is X high, or an A1C value that is X high. One can be created so that if the nutrition clinician enters the malnutrition diagnosis discretely, it fires an alert to the physician/APP the next time they go into the chart that you have identified/diagnosed malnutrition and the alert can include text such as for the provider to add malnutrition to the Problem List and please discuss the treatment plan in your progress note, for example. We do not employ these alerts at our hospital, but they are an option that I know other facilities use with success. Providers can suffer from alert fatigue, and not every time they go into the chart is the time they can do something about it.
Do you have any sample EHR TPN templates that you would be able to share?
The joint PN in EHR task force was vender nonspecific so we do not have specific EHR PN templates to share. Would recommend you work with your EHR vendor to see if they can share with you examples of EHR PN templates from some of their other customers.

We are interested in developing EHR based orders for enteral nutrition for home patients.  Any recommendations?  Anyone involved in this area, please contact me offline.
I am not aware that anyone has done this and is not aware of anyone who is currently doing this

What do you mean by discrete data, we have EPIC at my facility. Do you mean chart in a flow sheet which can be pulled?

Please see above for additional information about discrete date. If an entry is made into a flowsheet, many things are tracked behind the scenes including the location of the encounter and he date and time of the data entry. Each flowsheet row in EPIC has a specific ID. So if you want to retrieve the flowsheet row information to add it to your charting note, you would tell your IS person the name of the flowsheet row that you want, they can find the flowsheet row ID.

However, just because flowsheet row fields are discrete, it doesn't mean there are ways to retrieve all the data over time. We enter our NFPE data discretely for each site of the body and each possible physical finding. We discovered we had to go back into the note see the findings, so we requested a Chart Review Flowsheet to show NFPE and malnutrition data over time. Now we can monitor changes in physical findings over time – from the ambulatory to inpatient setting and back.

Dr. Kight, I would love to talk further about charting as I am currently working on charting for my organization. Could we speak further offline?

I'd be happy to help you if you have Epic software.