NUTRITION STATUS CLASSIFICATION SCHEME HANDBOOK

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook updates policy and guidance for the Department of Veterans Affairs (VA) Nutrition Status Classification Scheme, which is a resource for determining a patient's or resident's nutrition status. It is to be used by clinical nutrition staff.

2. SUMMARY OF MAJOR CHANGES. This revision of VHA Handbook 1109.01:

a. Incorporates Body Mass Index (BMI) and pre-albumin as alternate factors in the classification scheme.

b. Incorporates the interdisciplinary determination of nutritional risk into the general assessment process.

c. All guidelines and instructions on how to use the classification scheme are outlined on the Nutrition and Food Service (NFS) Website Link . Refer to Paragraph 6, for the website address.

d. VA Form 10-0364, Nutrition Status Classification Worksheet, a two-page worksheet, has been revised and is included as the resource for determining a patient's or resident's nutrition status.

3. RELATED DIRECTIVE. VHA Directive 1109, Nutrition and Food Service.

4. RESPONSIBLE OFFICE. The Director, Nutrition and Food Service (111N), Office of Patient Care Services, is responsible for the contents of this Handbook. Questions may be addressed to 202-273-8516.

5. RESCISSION. VHA Handbook 1109.1, dated March 15, 1996, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working date of August 2011.

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NUTRITION STATUS CLASSIFICATION SCHEME PROCEDURES

1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines the procedures necessary in the use of the Department of Veterans Affairs (VA) Nutrition Status Classification Scheme. The nutrition status indicates the nutrition acuity of the patients or residents and directly affects resources required for the delivery of quality nutrition care. ***NOTE:*** *The classification scheme was developed for use by clinical nutrition staff to determine the nutrition status of patients or resident*s.

2. DEFINITIONS

a. **Nutrition Screening.** A process to identify an individual who is malnourished or who is at risk for malnutrition in order to determine if a detailed nutrition assessment is indicated. Nutrition screening is usually completed within a specific timeframe as required by applicable Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) standards through the interdisciplinary admissions process. Each facility has determined the process and criteria it uses to identify patients or residents at risk. Patients or residents identified through the screening process are recognized as being at potential nutrition risk and are referred for further evaluation.

b. **Nutrition Assessment.** A comprehensive approach to defining nutrition status that uses medical, nutrition, and medication histories; physical examination; anthropometric measurements, and laboratory data. A formal nutrition assessment should provide all of the information necessary to develop an appropriate nutrition care plan. Nutrition assessment outcomes are identified by: the presence and degree of the risk for malnutrition; the need for nutrients; and whether or not those needs are being met. An assessment leads to a nutrition care plan that includes nutrition intervention, nutrition education and frequency of monitoring. The patient's or resident's nutrition status needs to provide a timeframe for reassessment. After completion of the nutrition assessment, a nutrition status is determined.

c. **Nutrition Status.** Nutrition status is defined as the patient's or resident's nutrition condition at a point in time. It is the end product of the nutrition assessment. The patient's or resident's nutrition status and local policy determine the priorities for nutrition intervention and reassessment. Patients and residents are classified at one of four nutrition status levels:

(1) **Level 1,** Normal Nutrition Status.

(2) **Level 2,** Mildly-compromised Nutrition Status.

(3) **Level 3,** Moderately-compromised Nutrition Status.

(4) **Level 4,** Severely-compromised Nutrition Status.

d. **Nutrition Status Indicators**

(1) The determination of nutrition status is based on seven commonly accepted indicator categories usually available at the time a nutrition screen or assessment is completed. A nutrition status can be determined for either inpatients or outpatients.

(2) There are seven indicators used in the Nutrition Status Classification Scheme. ***NOTE:*** *Each indicator is defined by descriptive patient criteria as outlined in Table 1, Nutrition Status Classification Scheme.* These indicators are:

(a) Nutrition History;

(b) Unintentional Weight Loss;

(c) Weight as a Percent (%) of Ideal Body Weight (IBW) or Body Mass Index (BMI);

(d) Diet;

(e) Diagnosis;

(f) Albumin or Prealbumin; and

(g) Total Lymphocyte Count (TLC).

e. **Obesity and/or Overweight.** The Nutrition Status Classification Scheme supports the United States Preventive Services Task Force (USPSTF) and the National Institutes of Health (NIH) guidelines for defining overweight and obesity based on BMI. These definitions are as follows:

Definition	**BMI**
Underweight	less than (<) 18.5
Normal Weight	18.5 to 24.9
Overweight	25 to 29.9
Obesity	30 or greater(>)

NOTE: *These definitions are also consistent with their application in the VHA Management of Overweight and/or Obesity for Veterans Everywhere (MOVE!) Weight Management Program, National Center for Health Promotion and Disease Prevention (NCP), Durham, NC.*

3. SCOPE

a. Title 38 United States Code (USC) Chapter 73 provides for the operation of NFS, and includes the provision of nutrition care and nutrition education. The JCAHO standards require that a nutrition assessment be completed on each patient or resident identified from the admissions screening process and that the nutrition status be recorded in the Computerized Patient Record System (CPRS) or progress notes.

b. This Handbook establishes mandated procedures for the nutrition assessment of patients or residents using the VA Nutrition Status Classification Scheme. It is to be used by clinical nutrition staff. The local VA facility's qualified dietetic professional staff (registered dietitians and others) are responsible for the completion of a patient's or resident's nutrition status.

4. RESPONSIBILITY OF THE FACILITY DIRECTOR

The facility Director, or designee, is responsible for ensuring that a nutrition assessment be completed by the facility's qualified dietetic professional staff (registered dietitians and others), on each patient, or resident, identified from the admission screening process.

5. NUTRITION STATUS INDICATORS

The following reflects the Nutrition Status Classification Scheme, Table 1, Nutrition Status Indicators.


Nutrition Status Indicators.pdf

6. REFERENCES

a. Title 38 U.S.C. Chapter 73.

b. Lowery, J, PhD, Hiller, L., MS, RD and et., "Comparison of Professional Judgment Versus an Algorithm for Nutrition Status Classification," Medical Care, pp.1578-1588: 1998.

c. Hiller, L., MS, RD, Lowery, J, PhD, MHSA, and et, "Nutritional status classification in the Department of Veterans Affairs," Journal of the American Dietetic Association (JADA), Vol. 101, No. 7, pp 786-792: July 2001.

d. Dwyer, Johanna T., Gallo, Joseph J, "Assessing Nutritional Status in Elderly Patients," American Family Physician, February 15, 1993.

e. VHA Handbook 1101.1, Management of Overweight and/or Obesity for Veterans Everywhere (MOVE!) Weight Management Program, National Center for Health Promotion and Disease Prevention, Durham, NC

f. Nutrition and Food Service web site: "Program Guidelines for Determining Nutrition Status Levels."
http://vaww.va.gov/nfs/clinical/ProgramGuidelinesforDeterminingNutritionStatusLevelFinal.doc

VA FORM 10-0364, NUTRITION STATUS CLASSIFICATION WORKSHEET

Below is an embedded copy of Department of Veterans Affairs (VA) Form 10-0364, Nutrition Status Classification Worksheet. The fillable version of VA Form 10-0364 can be found on the Veterans Health Administration (VHA) Forms website at: http://vaww.va.gov/vaforms . *(Unable to give exact link until directive is published)*

You should use the latest version of Adobe Acrobat Reader to view this form.

VA Form
10-0364-fill.pdf

Department of Veterans Affairs

Nutrition Status Classification Worksheet

SECTION A. NUTRITION HISTORY

1. Check ALL that apply. (The #'s correspond to Nutrition History rating categories)

Chewing problems	(2)	☐	Diarrhea	(3)	☐
Constipation	(2)	☐	Swallowing problems	(3)	☐
Nausea	(2)	☐	Vomiting	(3)	☐
Feeding assistance required	(2)	☐	None of above	(1)	☐
			Info. on pt. not available *(Leave Box 1 Blank)*		☐
Limited Activities of Daily Life	(2)	☐			
Restricted ambulation	(2)	☐			

Looking at the boxes you checked, place the highest corresponding value in BOX 1	1.

2. Check ONE of the following describing the patient's appetite:

Good	(1)	☐	Fair	(2)	☐	Poor (3) ☐	None (4) ☐

Place the # corresponding to the rating you checked in BOX 2. (*If info. not available Leave Box 2 Blank)*	2.
Compare the values in 1 and 2. Place the larger of the two in BOX A. This is the nutrition history rating.	**A.**

SECTION C. % IDEAL BODY WEIGHT

Patient's height (in inches or cms)	1	Patient's current weight (in lbs. or kgs.)	2
Frame size (default = medium)	3	Ideal body weight (Calculate from ht./wt.tables)	4

If the patient's height or weight is MISSING, STOP and Leave BOX C Blank.

Calculate % of ideal body weight: (2/4)*100=	5

% Ideal Body Weight Scores

% IBW Value	90-119	81-89 or 120-129	75-80 or 130-149	< 74 or 150>
Rating	1	2	3	4

Record patient's BMI	6

BMI Calculation Scores

IBW Value	18.5 - 24	17 - 18 25	15 - 16 26-29	< 15 >30
Rating	1	2	3	4

Using either % IBW or the BMI determine the %IBW/BMI rating. Place this rating in BOX C.	**C.**

SECTION B. UNINTENTIONAL WEIGHT LOSS

NOTE: STOP here and leave BOX B BLANK if any of the following is true:

1. past weight data or time frame is missing or > 6 months old
2. patient has gained weight or weight is stable
3. wt. loss is due to diuresis, amputation or sensible dieting

If not stated, assume wt. loss is unintentional.

Use data on the patient's most recent weight loss (unintentional only) to perform the following calculations:

Enter the previous weight and date. (lbs. or kgs.)	1.Wt	2. Date
Enter the current weight and date. (lbs. or kgs.)	3. Wt	4. Date

Calculate the following: Weight Change: 1-3= Time Period: 2-4= If 5 >0, calculate: % Weight Loss: (5/1)*100=	5. (Lbs or Kgs) 6. (Mos) 7. %
Using 6 (time) and 7 (percent) find the correct rating from the table below. Place this ACTUAL rating in BOX B.	**B.**

Unintentional Weight Loss Ratings

	Time Period			
Percent	<2 Weeks	2 Weeks-<2Months	2 Months-<4 Months	4 Months-<6 Months
<2	1	1	1	1
2-4.9	4	3	2	2
5-7.4	4	4	3	2
7.5-9.9	4	4	4	2
10-14.9	4	4	4	3
>=15	4	4	4	4

OVERALL RATING Transfer ratings of individual indicators to the following boxes.

Rating	A	B	C	D	E	F	G

Sum o f T op 3	Overall Status

Sum the 3 highest scores and place in the Sum box, then place the corresponding Status in the Overall Status box.

Sum of 3 top scores	3-5	6-8	9-11	12
Overall Nutrition Status	1	2	3	4

Nutrition Status Classification Worksheet Con't

SECTION D. DIET

Identify the patient's current diet(s) in the table below. Place the corresponding rating in BOX D (use the highest if more than one). NOTE: If there is NO ORDER STOP here and leave BOX D BLANK. If the patient's diet is not listed, write it under "Other" and use your clinical judgement in assigning a rating.

D. ☐

Rating	Diet Name		Rating	Diet Name		Rating	Diet Name	
(2)	ADA/Wt. Reduction	☐	(3)	Fluid restriction (<1000cc)	☐	(3)	Protein restricted	☐
(4)	Clear liquids/NPO > 5 days	☐	(2)	Full liquid	☐	(1)	Regular	☐
(3)	Clear liquids/NPO 3-5 days	☐	(2)	Lactose free	☐	(2)	Sodium restricted	☐
Blank	Clear liquids/NPO < 3 days	☐	(2)	Low fat/low cholesterol	☐	(4)	TPN	☐
(2)	Consistency other than mechanical	☐	(1)	Mechanical	☐	(2)	Tube feeding, stable	☐
(2)	Drug-nutrient interaction	☐	(3)	Mineral restricted other than sodium	☐	(3)	Tube feeding, unstable	☐
(2)	Dysphagia	☐	(4)	PPN	☐		Other	

SECTION E. DIAGNOSIS

Identify **all** of the patient's diagnoses in the table below. Find the diagnosis with the **highest** rating and place that rating in BOX E. A "rule out" diagnosis should be given the same rating as the diagnosis itself. This is not a complete list, so refer to the instructional manual for further detail. If no exact or close match exists, use your professional judgement and list the diagnosis here:

E. ☐

Rating	Diagnosis		Rating	Diagnosis		Rating	Diagnosis	
(3)	AIDS	☐	(3)	Dysphagia	☐		**Psychological Disorders:**	
(2)	Alzheimer's disease	☐	(3)	Endocrine, other than DM	☐	(2)	Eating disorders	☐
(2)	Angina	☐	(3)	Fracture, traumatic	☐	(1)	Others	☐
	Cancer:		(2)	Fracture, other	☐		**Pulmonary Disease:**	
(3)	Head & neck	☐		**GI Disease:**		(3)	O2 dependent	☐
(3)	GI tract	☐	(3)	w/malabsorption or	☐	(4)	Failure requiring ventilator	☐
(2)	All Others	☐	(2)	maldigestion	☐	(2)	Peripheral vascular disease	☐
			(2)	All others	☐		**Radiation Therapy:**	
(2)	Cardiac disease	☐	(4)	GI obstruction	☐	(3)	Head & neck	☐
(3)	Cardiomyopathy	☐	(3)	Head trauma	☐	(3)	GI tract	☐
(2)	Cellulitis	☐	(4)	Hepatic coma	☐	(2)	All others	☐
(3)	Chemotherapy	☐	(4)	Hepatic encephalopathy	☐	(2)	Renal disease	☐
(3)	CHF, acute	☐	(1)	HIV+	☐	(4)	Acute renal failure	☐
(3)	CHF, stable	☐	(1)	Hypertension (HTN)	☐	(3)	Chronic renal failure	☐
(2)	COPD, stable	☐	(4)	Ileus	☐	(3)	Spinal cord injury (SCI), new	☐
(3)	COPD, unstable	☐	(3)	Infection w/fever	☐	(4)	Sepsis	☐
(2)	CVA	☐	(3)	Liver disease	☐	(2)	Substance abuse	☐
(2)	Dementia	☐	(4)	Malnutrition	☐	(2)	Surgery, abdominal	☐
(2)	Diabetes: controlled	☐	(3)	Neurological disorders: coma	☐	(1)	Surgeries, all not mentioned	☐
(3)	Diabetes: uncontrolled	☐	(2)	Neurological disorders: others	☐	(2)	Total hip replacement	☐
(3)	Diabetes, newly diagnosed	☐	(2)	Nutritional anemia	☐	(2)	Tuberculosis	☐
			(2)	Pneumonia	☐	(1)	Urology disorders	☐

SECTION F. ALBUMIN LEVEL

Patient's most recent albumin level (g/dl) ☐

Patient's most recent prealbumin level (mg/dl) ☐

Site-Value for Albumin	No data OR > 6 Wks. old	☐	☐	☐	☐
:Pre-albumin Levels	No data	17-42	14-16	10-13	<10
Rating	Leave Blank	1	2	3	4

Using albumin or prealbumin, determine albumin/prealbumin rating Place rating in BOX F. **F** ☐

SECTION G. TOTAL LYMPHOCYTE COUNT

Patient's most recent TLC (cells/cmm) ☐

Find the TLC value in the table below and record the corresponding rating in BOX G. (cells/cmm)

TLC	No data or > 6 wks old	>1500	1200-1499	800-1199	<799
Rating	Leave Blank	1	2	3	4

Place the actual rating in BOX G. **G** ☐