

# Clinical Leadership and Innovation Help Achieve Malnutrition Quality Improvement Initiative Success



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## ABSTRACT

Malnutrition is a frequent, but often overlooked clinical issue that can significantly impact patient health outcomes and thus has been identified as a critical target for quality improvement. One recent advancement helping build momentum in quality improvement is the Malnutrition Quality Improvement Initiative (MQii). Frameworks like the MQii need clinical leadership to achieve success. A new taxonomy for clinical dietetics leadership describes five components of leadership behaviors—change, patient focus, self-direct, technical, and relationship—that align with the MQii tools and resources. Qualitative interviews were conducted with four clinical nutrition leaders from three health care systems or institutions who were part of the 2018-2019 MQii Learning Collaborative and had reported success and innovations using the MQii framework. The clinical dietetics leadership taxonomy was applied to describe how the clinical nutrition leaders demonstrated and supported leadership opportunities for clinical nutrition staff through implementation of the MQii.

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QUALITY IS AT THE CORE OF today's health care models, and quality improvement processes help drive effective change and advancement in clinical practice. Malnutrition is a frequent, but often overlooked clinical issue that can significantly impact patient and health outcomes and thus has been identified as a critical target for quality improvement.<sup>1</sup>

One recent advancement helping build momentum in acute care quality improvement is the Malnutrition Quality Improvement Initiative (MQii), a partnership between the Academy of Nutrition and Dietetics (Academy), Avalere Health, and other key stakeholders. The MQii provides measures,<sup>2</sup> clinical guidance resources through the MQii Toolkit,<sup>3</sup> and a learning collaborative, all designed to help advance evidence-based, high-quality care for hospitalized older patients ( $\geq 65$  years

of age) who are at risk for malnutrition or are already malnourished.

However, frameworks like the MQii need clinical leadership to achieve success. Quality improvement is a team process that requires a leader who can create and sustain a "personal and organizational focus on the needs of internal and external customers."<sup>4</sup> Leadership has also been identified as a core element for well-coordinated and integrated care, both from patient and health care professional perspectives.<sup>5</sup> Academy members have been specifically called on to lead the charge in the fight against malnutrition.<sup>6</sup>

Leadership can be demonstrated by those who have a formalized management role as well as by those who work via a more diffuse or shared process of influencing others in their organizations.<sup>7</sup> Informal leadership is the basis for a new leadership taxonomy for clinical dietetics practice developed by Patten and Sauer. The clinical dietetics leadership taxonomy includes five components of leadership, addressing: change, patient focus, self-direct, technical, and relationship behaviors (Figure 1).<sup>8</sup> The MQii Toolkit supports similar informal leadership behaviors for a successful quality initiative,

including guidance for project champions to encourage their teams to focus on delivery systems, patients, team-based processes, and the use of data.<sup>9</sup>

Patten and Sauer reported that the taxonomy supports one of the Academy's new principles, which is to "amplify the contribution of nutrition practitioners and expand workforce capacity and capability"<sup>10</sup> and that the taxonomy provides "clear and specific direction for clinical RDNs [registered dietitian nutritionists] as they develop their own leadership."<sup>8</sup> The taxonomy can also help define opportunities for clinical leadership in quality improvement. The current article applies the clinical dietetics leadership taxonomy to describe how RDNs at three health care systems or institutions are leading innovations and achieving success in quality improvement through implementation of the MQii.

## DEMONSTRATED BEHAVIORS OF THE CLINICAL DIETETICS LEADERSHIP TAXONOMY

Qualitative interviews were conducted with four clinical nutrition leaders from three health care systems or

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**Figure 1.** Clinical dietetics leadership taxonomy; adapted with permission from Patten and Sauer.<sup>8</sup> RDN=registered dietitian nutritionist.

institutions who were part of the MQii Learning Collaborative in 2018-2019. The clinical leaders had reported using MQii measures and tools to successfully implement quality improvement projects and innovations within their hospitals (Figure 2). The clinical dietetics leadership taxonomy was used to describe how the clinical leaders demonstrated various behaviors within the leadership taxonomy components—change, patient focus, self-direct, technical, and relationship—and the

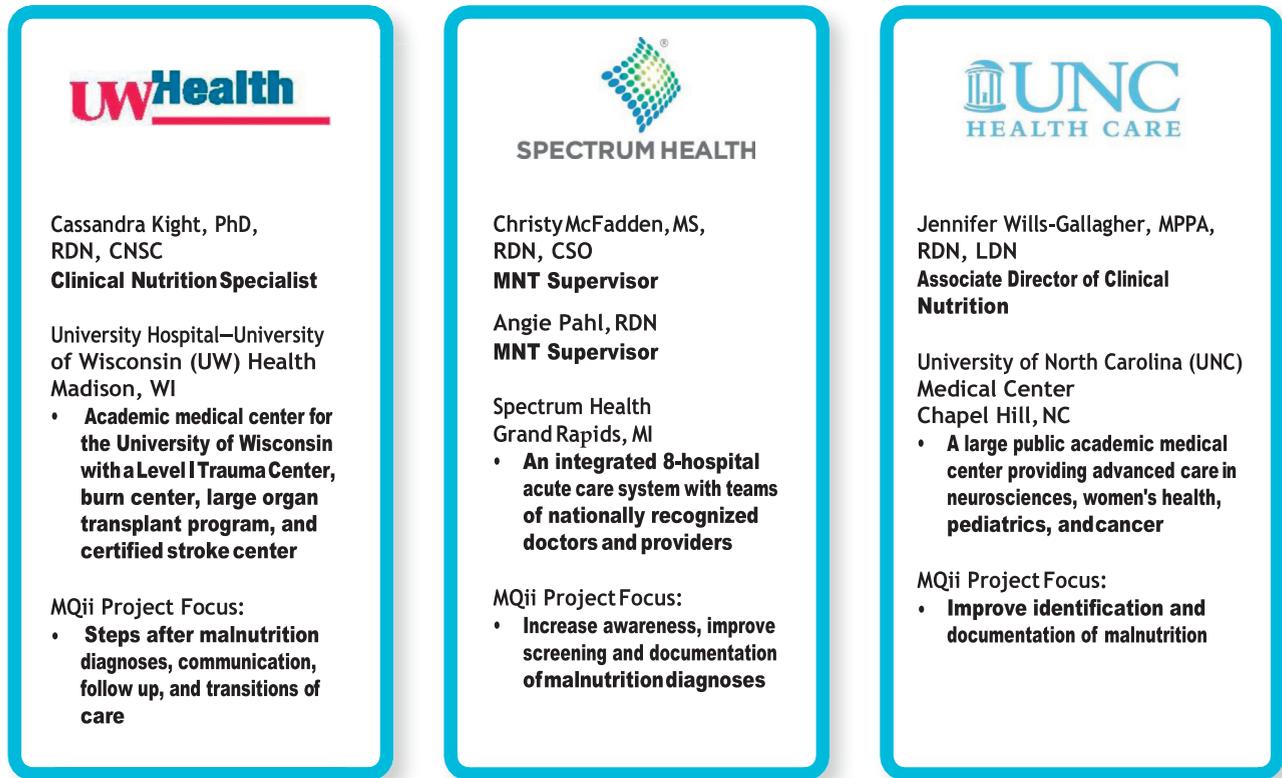
successful results of applying those behaviors.

**Change Behaviors**

Patten and Sauer identified the seven change behaviors of leaders as the ability to analyze the work environment, envision change, advocate change, improve work methods, build relationships with supporters, seek professional opportunities, and represent and promote the team.<sup>8</sup> The MQii Toolkit was designed specifically “to

support changes in the care team’s clinical knowledge of and use of best practices for malnutrition care.”<sup>9</sup> The importance of change behavior was consistently recognized during each interview with the four clinical nutrition leaders and was described as being an instrumental leadership skill during the planning and implementing of the MQii at each of their health care institutions.

Cassandra Kight, PhD, RDN, clinical nutrition specialist at University



**Figure 2.** Key characteristics and quality improvement initiatives of selected Malnutrition Quality Improvement Initiative (MQii) Learning Collaborative health care systems and institutions.

Hospital—University of Wisconsin (UW) Health in Madison, WI, explained how ongoing evaluation and analysis of work being done, such as skills training in the nutrition-focused physical examination, led to increased awareness of strengths and weakness in identifying and treating malnutrition and envisioning change. This was the precursor for the decision to implement the MQii. “The MQii really served as the framework for making change. Anytime there is something new in the workflow, it takes time to adapt to change, to get the clinical staff on board and understanding why change is needed. The MQii provided the tools to help us achieve successful change.”

Christy McFadden, MS, RDN, medical nutrition therapy supervisor at Spectrum Health in Grand Rapids, MI, stressed that in advocating for change, it is important to know the audience and be able to speak to their priorities. “When communicating the case for change and reaching out to get others to buy into new ideas or processes, you need to know where they are coming from—our hospitals were all at

different stages of the journey and the MQii Toolkit was particularly useful because it was so adaptable.”

Jennifer Wills-Gallagher, MPPA, RDN, LDN, associate director of clinical nutrition at University of North Carolina (UNC) Medical Center in Chapel Hill, NC, related that an important leadership skill is to build relationships with supporters. “A physician champion called me out of the blue because he had heard about the MQii. As we built a relationship with him and other multidisciplinary partners through the MQii, opportunities opened up that we simply could not have imagined. From developing a voice in the School of Medicine and School of Public Health project work to serving as a trajectory for personal growth, our relationships have been strengthened through representing and promoting the work of the MQii team.”

**Patient-Focus Behaviors**

Patient-focus behaviors in the clinical dietetics leadership taxonomy include those related to improving patient

satisfaction, outcomes, and safety.<sup>8</sup> Patient focus is instrumental to the MQii as well, because it was established “to advance evidence-based, high quality, patient-centered care for hospitalized older adults (age 65 and older) who are malnourished or at risk for malnutrition” and the MQii “places the patient at the center of the quality improvement process.”<sup>9</sup>

Indeed, improved patient outcomes are central to clinical care, as Kight described, “Our hospital is dedicated to quality improvement and improving patient care. We knew we could do more in our hospital for care of malnourished patients, who have a longer length of stay and greater rate of readmissions.” Kight identified that while University Hospital—UW Health was good at documenting the diagnosis of malnutrition, that diagnosis was often not communicated to the patient, which potentially impacted treatment plans and outcomes. Thus, increased patient engagement was one area of focus as the hospital implemented the MQii. A representative from the hospital’s patient and family advisory

group was included in initial MQii team meetings. Kight noted the benefits for patient discussions about malnutrition included opportunities for increased patient satisfaction and better connecting patients to services: “Patients know when they have lost weight, muscle, and strength. They are very appreciative when an RDN identifies and shares the malnutrition diagnosis with them because it confirms what they are already experiencing. As a result, the patients are more likely to follow through with treatment plans and referrals.”

McFadden commented that improving patient safety and experience is also of strong interest to other health care professionals on the MQii team at Spectrum Health. “One of the things everyone is talking about is how to improve patient safety. I found that I could reinforce the foundational role nutrition plays in patient safety and overall care by developing a catch phrase they could remember, like ‘Every body needs nutrition.’”

Wills-Gallagher shared that patient focus will continue to be important as UNC Medical Center moves into the next MQii project, improving care transitions. “UNC is becoming more focused on the social determinants of health,<sup>11</sup> so it made sense for us to zero in on care transitions and how we can better connect patients to community-based nutrition services. This was reinforced by the feedback received from the patient advocate engaged in our MQii process, who advised us on barriers for intervention after discharge and the challenges faced in the community for maintaining continued access to an RDN.”

## Self-Direct Behaviors

The clinical dietetics leadership taxonomy’s self-direct behaviors of prioritizing and planning work projects, assessing progress, and building cooperative relationships<sup>8</sup> are the core of quality improvement. These behaviors are reflected in the MQii Toolkit’s basic steps: plan your initiative, select your quality improvement focus, plan for data collection, begin implementation, and keep it going.<sup>9</sup>

“Building relationships across the organization and regularly reaching out to other departments is integral to MQii prioritization, planning, and

implementation and should not be an afterthought,” said McFadden. She explained that they reached out to Spectrum Health’s Information Services (IS) department at the start, when they kicked off an initial malnutrition prevalence study. “The request was made for a data pull to use as our benchmark. It took 9 months of persistence to get the data, but because of our continued outreach to IS, we have built a strong partnership that is now being leveraged to be able to report data through the MQii.”

Wills-Gallagher also described the importance of data, and being able to access it, so they could prioritize, plan, and assess progress on their MQii goals for UNC Medical Center. “Based on the initial data collected, we could see overall diagnosis of malnutrition was low and that there was a big difference between RDN documentation of malnutrition and physician diagnosis of malnutrition. The data were used to benchmark against the literature, and this helped better identify what we wanted to achieve.” Wills-Gallagher reported other lessons learned were to remeasure the data to assess progress and to use this information to “tell the story” of their success, and to tell it often!

Kight has been leading malnutrition care improvement at University Hospital—UW Health for several years. She identified that the MQii Readiness Questionnaire<sup>9</sup> was particularly useful for prioritizing and planning their MQii project. “We knew we needed to increase care team and patient and family participation in the development and execution of our hospital malnutrition treatment plans. We also needed to improve documentation of response to those plans and then look ahead to develop and communicate the discharge plans. The MQii provided the resources to help initiate meaningful change at University Hospital.”

## Technical Behaviors

Technical behaviors for a leader in clinical dietetics are described in three parts: developing mastery of clinical knowledge and skills, applying current research to primary care, and promoting the role of the RDN as a credible source of nutrition information.<sup>8</sup> These behaviors are interwoven throughout the MQii process.<sup>9</sup>

Angie Pahl, RDN, medical nutrition therapy supervisor at Spectrum Health, discussed how the MQii has helped further clinical skills and showcase the RDN. “Our work with the MQii has particularly opened up opportunities for some of our smaller facilities, where RDNs have become more engaged with multiple groups including a Falls Committee, Central Shared Nursing, and Colorectal Services. The RDNs may have talked to these groups before to request changes, but until the MQii, they never had the measures and data in hand to show what could be accomplished.”

“As clinicians, we all perceive ourselves as highly skilled,” added McFadden. “Through our engagement with the MQii, we have helped the RDNs learn where they can still grow and develop knowledge.” She went on to describe a unique health system contest implemented as part of their MQii project that aimed to provide education, increase awareness, and promote the role of the RDN as a credible source of information. “For Malnutrition Awareness Week, flyers were developed on malnutrition-related topics including the limited applicability of albumin as a diagnostic measure, the cost of malnutrition, and the role of the RDN. RDNs were incentivized to individually engage with clinicians. The RDNs documented 331 one-to-one malnutrition conversations with 68 physicians and 168 nurses during the week and that increased health team awareness of the role of RDNs, including the importance of RDNs conducting nutrition-focused physical examinations.”

Wills-Gallagher reinforced that the MQii provided momentum to feature the role of the RDN. “It is important to always have an ‘elevator pitch’ ready and to take advantage of every opportunity—even in the lunch line—to engage with others and share the importance and status of your malnutrition quality improvement work and the value of RDNs. Having the intervention data helped us fine-tune our messages to focus on the most meaningful improvements.”

As part of Kight’s leadership of the MQii implementation, unit RDNs were supported as they piloted new nursing workflows, identified issues, and provided suggested actions. “Nutrition screening usually isn’t the problem in many hospitals, it’s what happens next that needs improvement. With

implementation of the MQii, current research could be applied to develop better pathways for identification of patients at risk for malnutrition and improve documentation to show that nutrition care plans were being implemented. This also better positioned RDNs to strengthen clinical skills and engagement in transitions of care planning.”

### Relationship Behaviors

The relationship behaviors specified in the taxonomy—acting as mentor and engaging with a mentor as well as sharing and linking information with others<sup>8</sup>—are key to the leadership of quality improvement.<sup>9</sup>

McFadden described how engaging with a mentor was particularly helpful in MQii implementation. “Mentorship is regularly encouraged by our health system. A partner in human resources had urged me to reach out to the chief nursing officer to explore a mentorship opportunity. The chief nursing officer not only became a valued personal mentor, she also served as the executive sponsor for our MQii project implementation.” Pahl added that sharing and linking information with the Spectrum Health IS department was also critical to their MQii project success. “We regularly invested in building a relationship with IS, but it took some time to see results. We are now in regular contact with the MQii ‘data people’ and, as the IS director has gained a better understanding of our project, she has helped clear the path to regularly share information.”

Wills-Gallagher explained that for UNC Medical Center, capacity of the MQii team members was an obstacle, and it was often difficult to get everyone involved in the same room to share and link information. Although progress was sometimes slower than Wills-Gallagher would have liked, she overcame this obstacle by keeping the project a priority. “At times, I felt like an orchestra leader. As a decentralized group, the MQii team had lots of WebEx calls and part of my role was to keep the information flowing so everyone stayed in sync. Regular follow-up with team members occurred to confirm all involved contributed.” In addition, Wills-Gallagher worked to ensure the RDNs were held accountable, provided

with the proper tools, shared the outcomes of their work, and were ultimately recognized for their achievements.

For Kight, sharing and linking information with senior management as well as with the clinical team was equally important. “As a leader, you need to understand the limitations of your position in the management hierarchy and how others can help. It is also critical to have empathy for the clinical staff who will be implementing workflow changes. These skills are vital to help RDNs be part of the solution and not feel that they are suffering the consequences of quality improvement projects.”

### SUCCESSFUL INNOVATIONS

All three of the health care systems or institutions reported successful outcomes as a result of the leadership and innovations that came from planning and implementing the MQii. Increased awareness and understanding of malnutrition as well as elevating the role of RDNs were consistent benefits in each of the sites.

Wills-Gallagher explained that overall the team at her facility was more engaged and committed to improving practices to better care for patients and the clinical nutrition department was able to justify additional RDN full-time equivalents as a result of MQii quality improvement initiatives. According to Wills-Gallagher, “the RDNs gained credibility and a greater voice!” As described previously, moving the MQii to the next level is a current innovation area at UNC Medical Center. “We applied for and received an interdisciplinary health care quality improvement grant through the School of Family Medicine. With the grant, we now have a dedicated quality improvement coach who is helping us develop an MQii project for transitions of care from hospital discharge to the outpatient setting. It is a completely different area for our clinical nutrition practice, but one we would not have even considered without our initial involvement in the MQii.”

Similarly, McFadden described that one of their innovations was to plan and develop next steps for advancing malnutrition quality improvement beyond acute care to include discharge planning with transition to community care. Spectrum Health has been awarded

a grant to work with local home-delivered meal organizations to provide services for patients with heart failure and malnutrition. Specifically, they plan to study the impact of virtual RDN visits. McFadden described the grant funding as “a new opportunity that was made possible in part due to the implementation of MQii in the acute care setting.”

University Hospital—UW Health is focused on care transitions too. Kight explained the hospital’s Clinical Documentation Integrity manager is working closely with senior medical leadership to integrate the malnutrition diagnosis into the medical providers’ charting template. “We are also developing further supports for the discharge process, including implementing a critical access food pantry for the hospital’s food insecure patients later this year.”

The clinical nutrition leaders also used innovation to overcome barriers and drive malnutrition initiatives forward. Kight reported obstacles in engaging a critically needed team member and that communication was an ongoing concern. However, with persistence, effective communication was established with the team member to get the needs of the program met. Kight’s advice to others facing similar challenges is to “use your management and executive support to overcome obstacles that will have a major impact on the project timeline.”

### PRACTICE IMPLICATIONS

For over 25 years, Academy presidents have consistently championed the need for leadership development and practice,<sup>12–16</sup> including recent work to “ensure members are *the* recognized experts who lead the fight against malnutrition.”<sup>17</sup> Patten and Sauer found that leadership behavior for clinical RDNs was not constrained to level of education, years of experience, or specialty certification. However, they did identify that clinical RDNs who “assessed themselves as involved or very involved professionally had significantly higher mean composite scores [on the clinical dietetics leadership taxonomy] than those who were not involved or were somewhat involved.”<sup>18</sup> As documented in this article, the MQii can provide a

meaningful opportunity for supporting professional leadership involvement.

Patten and Sauer also identified that “nearly one-third of participants thought that workplace politics prevented them from demonstrating the level of leadership they would like.” In addition, they recommended careful investigation of specific workplace environments and structures to assess barriers to clinical leadership.<sup>18</sup> The clinical leaders profiled in this article described how their use of the MQii tools and resources helped RDNs to overcome barriers and innovate successful quality improvement projects. Thus, the MQii may provide a road map for navigating some of the challenges of workplace politics and offers specific tools to help clinical leaders assess obstacles and structure processes for the organization’s practice improvement. As Wills-Gallagher summarized, “Using the MQii helped change our leadership practices. The RDN team now has a much greater awareness of how much data matter to our decision makers. Thus, the clinical nutrition department vision has recently evolved to include becoming a more data-driven team.”

## CONCLUSIONS

Clinical leadership is an informal process that is demonstrated through a range of behaviors. The recently developed leadership taxonomy for clinical dietetics practice encompasses behaviors that align with the quality improvement process and are reflected

in the tools and resources of the MQii. Leading the implementation of an MQii quality improvement project can yield successful patient outcomes and may also provide an opportunity to help RDNs develop necessary leadership skills toward achieving the expert stage of career development, which, as defined by the Academy’s Career Development Guide, requires the demonstration of leadership.<sup>19</sup> In addition, clinical leadership and innovation can help achieve MQii success.

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**STATEMENT OF POTENTIAL CONFLICT OF INTEREST**

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**AUTHOR CONTRIBUTIONS**

M. B. Arensberg, C. D'Andrea, and M. Khan developed an interview questionnaire and conducted the interviews. M. B. Arensberg and C. D'Andrea wrote the draft with contributions from M. Khan. All authors reviewed and commented on subsequent drafts of the manuscript.