Interdisciplinary Team Engagement and Key Learnings

The Importance of Nutrition Post-Discharge Interventions

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Learning Objective: To discuss the benefits of utilizing a quality improvement process to identify gaps and opportunities in an established malnutrition initiative.

Relevance: Malnutrition initiatives were implemented to improve the quality of malnutrition care, standardize practices, and increase awareness of the importance of the care of malnourished patients. Healthcare is always changing, and established initiatives or programs need to be evaluated often to stay relevant to current trends.

Quality Improvement Process on Which Initiative is Based: The Malnutrition Quality Improvement Initiative (MQii) Toolkit was used to review current practices and ensure key points were in place including the electronic clinical quality measures, establishing key stakeholders on the interdisciplinary team, and education. The Malnutrition Care Assessment and Decision Tool was used to review current malnutrition initiatives across several hospitals in the health care system. The tool identified the discharge planning process as an area for improvement and further investigation. A process and data collection were developed that focused on all patients diagnosed by the registered dietitian nutritionist (RDN) with severe malnutrition in a two month period. Their charts were reviewed by an RDN and included collection of prescribed RDN nutrition recommendations, discharge location, and information obtained through follow-up phone calls that focused on compliance with RDN recommendations. Follow-up phone calls were performed on only those patients discharged home.

Results / Key Learnings: Preliminary data indicates favorable and unanticipated findings. Patients called via the protocol established were well versed on the recommendations from the inpatient RDN and the vast majority were following instructions based on nutrition prescription. Of those who could not verbalize recommendations were able to reference written discharge instructions that were entered into the medical record by the RDN and reviewed by the discharging nurse prior to returning home. What was surprising was the number of patients that did not meet criteria for follow-up calls. Patients discharged to short/long term care facilities, skilled nursing facilities or other institutions comprised the majority of the Severe Malnutrition diagnosis list.

Conclusions: Using the Malnutrition Care Assessment and Decision Tool provided by the MQii was helpful in highlighting opportunities to improve the discharge piece of malnutrition initiatives. The process of nutrition assessment with RDN-driven patient education regarding diet modifications and oral nutrition supplement use, followed by RN reinforcement and written guidelines provided at discharge, is helpful to aid in memory retention of nutrition recommendations. Patients tend to understand the importance of diet and supplements and follow nutrition prescriptions. The majority of severely malnourished patients are not discharged home but are discharged to other facilities requiring a deeper dive into these discharge processes as they comprise a greater proportion of malnourished patients.

Implications for Policy or Practice: RDNs are making quantifiable impacts in hospitals nationwide and improving measurable outcomes for the most at-risk populations. Utilizing comprehensive approaches like the MQii, to identify gaps in service is proving to be most effective given the results TouchPoint Support Services has come to find. Moving forward, fostering an open communication system to disseminate nutrition recommendations with outside facilities will be imperative to reduce readmissions and improve outcomes for the malnourished population.

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Physician Champions: Key to Malnutrition Diagnosis Identification and Documentation

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Learning Objective: Discuss physician champion’s role in facilitating physician engagement in the dietitian Nutrition Focused Physical Exam (NFPE) training and competency validation program.

Share implementation of the malnutrition diagnosis identification query in the electronic health record (EHR) for the improvements in malnutrition identification and subsequent patient care.

Relevance: The prevention and treatment of malnutrition in hospitalized patients improves the quality of patient care, clinical outcomes, and reduces cost. However, malnutrition remains under recognized and undertreated. As a participant of the Malnutrition Quality Improvement Initiative (MQii) collaborative, Overlook Medical Center (OMC) conducted a gap analysis of malnutrition clinical workflow. Gap analysis data revealed the malnutrition diagnosis rate among total admitted patient was 5.28% which is 34% below the national surveillance data average of 8%. Also, in comparison to registered dietitian nutritionist’s (RDN’s) high risk and moderate risk assessment, physician’s recognition of malnutrition diagnosis was only 17%. Therefore, malnutrition diagnosis identification and documentation were prioritized as OMC quality improvement initiative. Additionally, several gaps were identified, including a lack of interdisciplinary clinician participation in the delivery of malnutrition care, inadequate knowledge about or use of nutrition tools, and inadequate staff training of the NFPE.

Quality Improvement Process on Which Initiative is Based: Utilizing information from the MQii Toolkit, physician champions Chief Medical Officer, Physician Residency Program Medical Director, and Hospitalists Directors were briefed on the value of quality malnutrition care, the recommended nutrition clinical processes, an etiology-based approach to the diagnosis of malnutrition in adult hospitalized patients, and the gap analysis data.

An NFPE validation program was developed to enhance RDNs’ skills and build credibility with medical staff. RDNs conducted 10 NFPEs with resident physicians and observed resident performing the exam. Weekly discussions on NFPE-related challenges and successes were conducted among the RDNs. All RDNs completed the NFPE competency exam which was conducted by a team of physicians, the clinical nutrition manager, and the lead RDN. Additionally, utilizing insight and expertise physician champions, a malnutrition identification query was developed and implemented in the EHR. The query is documentation for the physician stipulating the RDN’s assessment of the patient’s malnutrition status.

Results / Key Learnings: Results indicated that 83.5% of all malnutrition queries were acknowledged by physicians which led to a 25% increase in malnutrition coding from the baseline in the first two quarters and a 70% increase in the third quarter following implementation.

Conclusions: Physician champions not only helped in securing institutional support for the initiative, but also facilitated physician engagement in the RDN NFPE training and competency validation program. This program proved to be crucial in building credibility with the medical staff and further development, approval, and implementation of the malnutrition diagnosis identification query in the EHR. This physician engagement with RDNs has resulted in significant improvements in malnutrition identification and subsequent patient care.

Implications for Policy or Practice: The aim was to raise awareness and promote collaboration between physicians and RDNs to improve malnutrition documentation by incorporating the recommendation of the 2012 Consensus Statement from the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition including NFPE documentation and etiology-based approach to the diagnosis of adult malnutrition in clinical settings.

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