Welcome to Today’s
Expert Webinar for the 2018 MQii Learning
Collaborative:

“Performing Malnutrition Screenings”

We will get started promptly at
12:00PM ET
(11:00AM CT; 10:00AM MT; 9:00AM PT)

All phone lines have been muted
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# Today’s Agenda

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Christina Biesemeier, MS, RD, LDN, FADA, FAND

Director of Clinical Nutrition Services,
Vanderbilt University Medical Center

- Importance of Nutrition Screening
- How to Work with an Interdisciplinary Team to Perform Effective Screening
- Experience at Vanderbilt University Medical Center
Disclosures

- Editor-in-Chief of the Academy of Nutrition and Dietetics Nutrition Care Manual
Definition of Malnutrition & Its Impact

• “An acute, sub-acute or chronic state of nutrition in which a combination of varying degrees of overnutrition or undernutrition, with or without inflammatory activity, have led to a change in body composition and diminished function.” (White, *JPEN*, 2012)

• **Impact of Malnutrition**
  - Altered response to medical and surgical therapy
  - Direct association with higher complications:
    - Impaired wound healing
    - Increased post-operative infection rates
    - Increased mortality
    - Longer length of stay in the hospital
    - Increased cost of care
Prevalence of Malnutrition

- Review of 20 different prospective and retrospective studies investigating the rate of malnutrition (Norman, *Clin Nutr*, 2008)
  - Range of 20% to 50%
  - Weighted mean of all studies of 41.7%
  - 7 Studies used the Subjective Global Assessment to ID malnutrition

  - Studies included a focused effort to identify malnutrition using the Malnutrition Clinical Characteristics (MCC's) based on the Academy of Nutrition and Dietetics/ASPEN Adult Malnutrition Concensus Statement (2012)
  - Malnutrition rate: Range of 20-50%
The Problem: Failure to Recognize At-Risk Patients

- Malnutrition is under-recognized and an unaddressed problem in many hospitals
     - Rate of reported malnutrition in 2010 = 3.2%
     - The rate of reported malnutrition increased during this time interval
  2) University HealthSystem Consortium (UHC)/Vizient data for FY 2014 - 2015
     - Data available for 105 of 112 University Medical Centers & ~5.9 million hospitalized patients (Tobert, *J Acad Nutr Diet*, 2018):
       - 5% of patients had a diagnosis of any malnutrition (Median institutional rate = 4.0%; range = 0.6% to 18.6%)
       - 1.4% of patients had a diagnosis of severe malnutrition (Median prevalence rate of 0.9%; range = 0.0% to 10.3%)
       - Documentation of malnutrition improved from 2014 to 2015
       - Any malnutrition – from 4.0% to 4.9%; Severe malnutrition – from 0.7% to 1.1%

- Nutrition screening is a requirement for hospital accreditation by The Joint Commission

- Nutrition Intervention for malnutrition is based on Nutrition Screening and the Nutrition Care Process
What's Going On?

Increased reporting of malnutrition is associated with:

1. Higher patient volumes,
2. Being in the top 50 of U.S. News and World Report hospitals rankings, and
3. Higher patient experience star score (HCAHPS score).

A variety of contributing factors has been reported:

- Lack of awareness
- Insufficient education and training of health care providers (Argiles, 2005)
- Inadequate RDN support/staffing
- Lack of interdisciplinary team participation in the delivery of nutrition care
- Barriers to implementation of nutrition interventions after diagnosis (Tolbert, 2018)
- Use of multiple definitions to identify malnutrition
- Lack of a single marker for malnutrition
- Variety in the manifestation of malnutrition in humans
- Inability to demonstrate early improvements in malnutrition with intervention, leading some to question the effectiveness of the interventions
- Physician approach to managing nutrition care doesn't include the integrated approach needed for positive outcomes
- Health care providers do not always change practice based on the evidence

(Correia, J Acad Nutr Diet, 2018)
Working with an Interdisciplinary Team – Enhances Ability to Manage Malnutrition

- Network – Identify interested partners
- Sell the problem, not the solution – from several angles and with real-life impact
- Raise awareness with Hospital Administrators about the impact of the problem – Decreased ALOS = decreased cost
- Be aware of the impact on team members' work load and time commitment
- Use technology to “require” nutrition screening and to streamline documentation, when possible
- Remember that the patient is the central member of the patient care team & educate patients & family members
- Be single-minded and stay focused
Experience at Vanderbilt University Medical Center

• **Field Testing** of the Malnutrition Quality Improvement Initiative Toolkit demonstration developed by the Academy and Avalere based on information obtained from interviews with healthcare providers about gaps in the health care workflow – January 2016

• **Nutrition Screening**: Audits to determine completion rates, performance improvement “work” = Improvement + some continuing gaps

• **Nutrition Diagnosis of Malnutrition**: 11 week audit in both adult and pediatric hospitals to determine our Nutrition Diagnosis rate
  – Adult patients with any malnutrition = 7.7%
  – Adult patients with moderate malnutrition = 2.7%
  – Adult patients with severe malnutrition = 5.0%

Follow-up:
  – Training of RDs – Nutrition Assessment using MCCs & Nutrition Focused Physical Exams, and Malnutrition Documentation
  – Collaboration with Clinical Documentation Specialists = System for easy identification by CDS of RD documentation, leading to queries to providers
Experience at Vanderbilt University Medical Center

Single Vendor EHR:
Decision made in 2015
Late 2015 – EPIC selected as vendor
Implementation date selected – November 2, 2017 – All VUMC on the same day

Impact:
**Planning for EPIC a priority** – 1) Review of Work Flows, 2) Care Process Development & Documentation; 3) Orders for nutrition, 4) Interdisciplinary processes

**No changes in current systems** – Limited changes in orders allowed

- Decision made to use Malnutrition Screening Tool (MST) for adult patients and STAMP Protocol for pediatric patients in Nursing Admit History

**MST and STAMP** put into operation by Clinical Nutrition - “Manual System”

- Development continued for ~2 years, including autopopulation of interdisciplinary fields: Nutrition Diagnoses (Patient Story) + RD recommendations and malnutrition diagnosis (Patient Summary) – Limited ability to view and refine during development

**Our Reality:** Plans had to be curtailed – “no changes to current nutrition screens” = Obtained agreement to change 2 questions r/t appetite and weight loss AND imbed MST calculations in our EHR + **MST Report**
Experience at Vanderbilt University Medical Center

Implementation and Immediate Refinement to enable operation
Assigned a SWAT team – Administrative oversight + Goals to resolve issues & quickly

Stabilization – Further Refinements

Optimization – Where we are now and will be into the future:
- MQii Malnutrition Care Assessment and Decision Tool – What are our issues?
- The 4 Disciplines of Execution Operations System – FranklinCovey Co., 2012

1) **Setting Wildly Important Goals** – “from x to y by when” (aka Lag Measures)
   - **WIG Areas** – Limited number & specific:
     - Identifying and treating malnutrition (Inpatient only)
     - Demonstrating the impact of nutrition interventions by tracking patient outcomes (Inpatient and Outpatient)

2) Once WIGs are defined, we'll select **Lead Measures** – Predictive and can be influenced by staff in real time – Measures of behaviors that, if done, lead to goal achievement

3) **Scoreboards**
4) **Frequent Review** of actions taken, barriers, and next accountabilities
Experience at Vanderbilt University Medical Center

Optimization
Incorporating the Initiative into Core Department Operation

- **Department Champions** – Clinical Group Leaders and Project Leaders (Career Ladder)
- **Incorporation into Performance Management System** – WIGS are our Department Annual Goals and link to VUMC Cascade Goals – Annual evals rate contribution to achievement

Use of Academy of Nutrition and Dietetics Health Informatics Infrastructure (ANDHII.org)

- **Secure, web-based platform** that stores patient data, diagnoses and intervention details using the **Nutrition Care Process Terminology (NCPT)**
- Provides tools for RDs to **demonstrate their interventions’ impacts** by tracking patient and client outcomes
- Adds data (anonymous) to the national **Dietetics Outcomes Registry**, contributing to the evidence supporting nutrition practice and helping ensure high-quality patient care

EPIC Reports

- **Nutrition Care Plan** – Diagnosis, Goals, Intervention, Outcomes
- **eCQMs**
Take-Home Points

• Use an Evidence-Based Approach
• Promote Staff Engagement in the Process (4DX)
• Stay Focused – Don't try to do too many things at once!
• Form Partnerships with your Health Care Colleagues
• Be Flexible and Persistent
• Move into Positions with Budget Control & Staff Management so you can be a Decision-Maker
Exhibit Leadership in Your Organization

“True leaders define and achieve enduring success by developing character and competence and taking principled action; they don’t wait for others to define it for them.

Because they see themselves as uniquely gifted, they compete against no one but themselves.

These leaders create their own future.”

... Stephen Covey
• Implementing a Malnutrition Screening Quality Improvement Initiative

• Tools & Interventions Used at New Hanover Regional Medical Center

• Insights & Lessons Learned

Angela Lago, MS, RD, LDN, CNSC

Clinical Nutrition Manager,
New Hanover Regional Medical Center

The Malnutrition Quality Improvement Initiative (MQii) is a project of the Academy of Nutrition and Dietetics, Avalere Health, and other stakeholders who provided guidance and expertise through a collaborative partnership. Support provided by Abbott.
Disclosures

- Nothing to disclose
New Hanover Regional Medical Center
QI Focus Areas (GAPS)

- **Nursing: Admission Screen & Overall Awareness of Nutrition Workflow**
- MD Communication / Education
- Discharge / Post-Discharge
  
  *(Transition of Care)*
QI Interventions & Implementation

- **Streamline Screening Tool**
- **Nurse Education**

![Nutrition - Nutrition Screening](image-url)
QI Interventions & Implementation

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QI Interventions & Implementation

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**Nursing Nutrition Screening**

*Within 24 Hours of Admission*

**February 19, 2018**

**Purpose:** Nursing completes an initial nutrition risk screening within 24 hours of the patient’s admission to ensure timely identification of patients at nutrition risk.

**Nursing Nutrition Screening:**

- Is to be performed within the **first 24 hours** of the patient’s admission.
- The nursing nutrition screening is the main way Registered Dietitians identify patients at nutrition risk.
- Patients whose nutrition screening score is $\geq 2$ are at nutrition risk.
- Patients at nutrition risk will automatically receive oral nutrition supplements with their next meal tray.
- An automatic Nutrition Consult is generated for patients identified at nutrition risk.

**Malnutrition:**

- Is the leading cause of morbidity and mortality
- 20-50% of patients are at risk for malnutrition at the time of hospital admission
- 31% of malnourished patient experience further nutritional decline during hospitalization
- Malnourished patients may experience continued decline after discharge, which results in a higher likelihood of readmission

**Nursing’s Nutrition Screening and Malnutrition Awareness Contributes To:**

- Improved patient care and outcomes
- Transitions of care
- Decreased readmission
- Continuous quality improvement
- Improved hospital reimbursement
QI Interventions & Implementation

• **Streamline Screening Tool**
• **Nurse Education**

- Nursing Congress / Practice Council
- Clinical Informatics Council
- Nurse Manager Congress
- Nurse Manager Meetings
- Utilization Management Meetings
- Medical Record Review Team
Long-term trends on performance data were measured from November 2017 to June 2018. Results below indicate the relative change in performance across that timeframe:

- **eCQM 1 Screening:** -1.53% relative change since November 2017 (post-implementation period)
  - The performance on this measure has remained relatively steady around 76-80%
  - Staffing levels seem to be contributing to a systematic cap for hospitals across the collaborative.
  - Additionally, patient subpopulations with different screening needs could account for this persistent gap
  - The ACCURACY has improved significantly! 86 (13%) inaccurate nursing nutrition screens in March 2015 vs 13 (4%) inaccurate nursing nutrition screens in March 2018.

- **eCQM 2 Assessment:** +3.90% relative change since November 2017 (post-implementation period)
  - Likely that staffing limitations could be impacting slow improvement
Create a team of high performers that are passionate about making a difference and doing worthwhile work!
Executive level support is key!
Nurse manager accountability is necessary!
Get used to talking about malnutrition A LOT!
This is a marathon, not a sprint!
The nutrition screen is the link to every other process you will put in place...

- **Nutrition Screen**
  - RD Assessment
  - Early ONS/Intervention
  - Nutrition Diagnosis

- **MD Communication**
  - Best Practice Alert
  - Malnutrition on Problem List / documentation
  - MD awareness

- **Transition of Care**
  - Community/Home Health RD
  - Continuity of Care after d/c
  - Community Services link
Questions?

15 mins
CPEU Credit

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