Welcome to Today’s Expert Webinar for the 2019 MQii Learning Collaborative:

“Acute Care to Next Site of Care Hand Offs: Continuation of the Nutrition Plan, Documentation, Intervention and Implementation”

Tuesday, June 25, 2019
We will get started promptly at 2:00PM ET
(1:00PM CT; 12:00PM MT; 11:00AM PT)

All phone lines have been muted
• NHRMC’s Malnutrition Journey
• Implementing a Transitions of Care (ToC) program
• Impacts, Outcomes and Future
New Hanover Regional Medical Center
Our Malnutrition Journey
Our Malnutrition Journey: Impact

✓ Increased malnutrition capture rate from 3.2% to 7.5% in 6 months.

✓ Increased reimbursement significantly with increase in capture rate.

✓ Correlated a decrease in mortality index with increase in malnutrition capture rate.

✓ Gained visibility within organization.
Our Malnutrition Journey: Impact
Our Malnutrition Journey: The MQii

- Promote early identification and treatment of malnourished patients
- Communicate the nutrition plan and interventions to the medical team, utilizing EMR as able
- Outline a discharge plan that meets the specific needs of each patient

The nutrition screen is the link to every other process you will put in place...
Our Malnutrition Journey: The MQii

Malnutrition eCQM Performance Data
Learning Collaborative 2.0 - July Cohort
New Hanover Regional Medical Center
September 11, 2017

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Measure Population</th>
<th>Measure Population</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Performance Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of a Nutrition Assessment for Patients</td>
<td>1693</td>
<td>135</td>
<td>3</td>
<td>332</td>
<td>201</td>
</tr>
<tr>
<td>Age 65+ Years who are At Risk for Malnutrition within 24 hours of a screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Completion of a Nutrition Assessment for Patients (Age 65+) identified as At-Risk for Malnutrition within 48 hours of a Malnutrition Screening

| | Denominator | Patients with Nutrition Assessment Completed | # Completed within 48 hrs |
| |            |                                               |                         |
| | 332        | 201                                            | 98                       |

Looking at the difference between this indicator and eCQM #2, there are about 55 patients which fell within the 24-48 hour range.

Best Practice Guidelines

Vs.

Our policy
Malnutrition Transitions of Care: First Steps
The NHRCM Community Paramedic Program is an innovative way to care for patients outside the hospital. Paramedics with NHRCM EMS work with patients in their homes to help them find ways to better manage their conditions, avoiding recurring trips to the hospital.

The goal of the program is not to duplicate services already available to the patient, but to answer questions, assess the patients’ needs and help them navigate the resources available in the community. In some cases, Community Paramedics can provide treatments or specialized diagnostic testing in a patient’s home.

NHRCM Community Paramedics have completed 300 hours of specialized training in addition to their paramedic education. This expanded level of training allows the Community Paramedic to collaborate more effectively with all members of the patient’s healthcare team in order to support the needs of each patient.

**Caring for Patients**

**Outside the Hospital**

**HEALTH CARE**

2015 GRANTMAKING IN HEALTH CARE

**62 NEW GRANTS**

$53.3 million

A total of $53.3 million was distributed, some of which was from commitments approved in previous years.

**James P. Biddle**

THE DUKE ENDOWMENT

Enhancing the lives of individuals and the vitality of communities by promoting prevention, improving the quality and safety of services and increasing access to care.
Malnutrition Transitions of Care: Food Insecurity

Food Insecurity Screen by SW

Date: October 1-10, 2018

✓ 260 patients screened
✓ 20% identified as Food Insecure
✓ 4% Malnourished & Food Insecure

NHRMC FOOD KIT

Nutrition plays an important role in helping you heal and gain strength for your recovery. The food in this kit should feed you for seven days. Please note that this food kit contains perishable items that need to be refrigerated within three hours.

This kit contains:
- Sliced turkey
- Sliced cheese
- Bread
- Condiments
- Peanut butter
- Jelly
- Canned tuna
- Pasta
- Graham crackers
- Oatmeal or grits
- Cookies

Meal ideas using ingredients in Kit:
- Turkey & cheese sandwich w/ mustard and mayonnaise
- Peanut butter & graham crackers
- Peanut butter & jelly sandwich
- Tuna Sandwich (using mayonnaise, mustard and relish)
- Buttered pasta w/ tuna
- Yogurt w/ granola on top
- Cheesy grits
- Macaroni & cheese
- Tuna Noodle Casserole

MQii™
Malnutrition Transitions of Care: Workflow

1. Nursing Nutrition Screen by RN
2. Nutrition risk identified (<2 score): RD assessment
3. No Nutrition Risk Identified (<2 score): No RD intervention, will see at LOS or Consult
4. No nutrional diagnosis = sign off
5. Nutrition diagnosis assigned and/or planned
6. Non-Malnutrition diagnosis
7. Inpatient RD creates Discharge Care Plan, doc in AVS and explains to patient before discharge
8. RD training
9. ED training
10. Excluded to Transition Care Managers (Jean/Chants)
11. Discharge Phone Call by Cell Manager RNs and nutrition concerns
12. Request for Food Kit sent to PHM. Delivered before d/c. RD documents if patient refuses
13. RD referral to Clinical Outreach RD
14. Does patient have high risk readmission diagnosis?
   - Yes: Send Nutrition Risk Communication on CMR
   - No: Referral to Clinical Outreach Dietitian
15. Malnut AND Food insecurity AND/OR High Risk Readmission
Malnutrition Transitions of Care: **Workflow**

**Low Risk**
- **Characteristics include:**
- Second encounter
  - Home visit and NPIE at 1 month post discharge
- Third encounter
  - Home visit and NPIE at 3 months post discharge

**Moderate Risk**
- **Characteristics include:**
- Second encounter
  - Home visit within 2 weeks after discharge
- Third encounter
  - Home visit and NPIE at 1 month post discharge
- Fourth encounter
  - Home visit and NPIE at 3 months post discharge

**High Risk**
- **Characteristics include:**
- Second encounter
  - Home visit within 1 week after discharge
- Third encounter
  - Call at 2 weeks post discharge
- Fourth encounter
  - Call at 3 weeks post discharge
- Fifth encounter
  - Home visit and NPIE at 3 months post discharge

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**First encounter:** Call within 48 hours of discharge
1. Review nutrition plan of care
2. Review food list
3. Review CNS if applicable
4. Assess risk / Needs

**COPD needs notification if security risk / dangerous location**

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**Referral to Clinical Outreach Diatian Received**

**Clinical Outreach Diatian reviews EMR and calls each patient to assign a Risk Level**
# Malnutrition Transitions of Care: Workflow

**Standard Work:** Malnutrition Transitions of Care

**Origin Date:** January 7, 2019  
**Revision Date:** N/A

<table>
<thead>
<tr>
<th>Step</th>
<th>Major Steps (What) (When) (High Level Steps)</th>
<th>Key Points (How) (Who) (Detailed Steps)</th>
<th>Reasons for Key Points (Why)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient is diagnosed with malnutrition during hospitalization.</td>
<td>Registered Dietitians (RD) working in the acute care setting assess patients that are at risk for malnutrition. If the patient meets the criteria, according to the ASPEN guidelines, a diagnosis of malnutrition is given to the patient.</td>
<td>It is important to promptly implement clinical strategies to address malnutrition and to coordinate care for malnourished and at-risk patients.</td>
</tr>
<tr>
<td>2</td>
<td>Patient is screened for Food Insecurity</td>
<td>RD’s screen each patient diagnosed with malnutrition for Food Insecurity (FI) using the Hunger Vital Signs validated screening tool</td>
<td>Patients that are malnourished and FI will not have the resources to nourish their bodies back to a healthy state once they return home.</td>
</tr>
<tr>
<td>3</td>
<td>Referral is made to Clinical Outreach Registered Dietitian (CORD).</td>
<td>RD’s order a CORD referral for each patient that is diagnosed with malnutrition during their hospital stay.</td>
<td>Early identification and systematic nutrition care coupled with interdisciplinary team-based care are critical in remediating malnutrition in the hospital, community, and post-acute care settings.</td>
</tr>
<tr>
<td>4</td>
<td>If FI, order for Food Box at discharge and Social Work consult is placed.</td>
<td>RD’s order a Food Box for patients being discharged to home setting. A Social Work (SW) is placed at the same time as the Food Box order.</td>
<td>Food boxes are prepared and stored in Food &amp; Nutrition until sent home with patient. Each box provides approx. 2000 kcal/day for 2 weeks, if consumed by only 1 person. The SW in Integral In alerting the RD of the approximate date / time of discharge.</td>
</tr>
<tr>
<td>5</td>
<td>Patient is discharged and Food Box is delivered</td>
<td>RD’s work with SW to determine exact time of discharge. RD ensures Food Box is delivered to patients room near time of discharge.</td>
<td>It is important to deliver the food box close to discharge, as several items in the box are perishable. The food box is labeled with a “refrigerate by” time. If necessary, perishable items can be removed, in the event that the...</td>
</tr>
</tbody>
</table>
Malnutrition Transitions of Care: EMR
Malnutrition Transitions of Care: Home Visit

Nutrition

Default Flowsheet Data (all recorded)

Community Dietician
Row Name 06/19/19
1615
Clinical Outreach Dietician
Who referred the patient to Clinical Outreach RD? RD
What degree of malnutrition does the patient have? severe
What is the context of the patient's malnutrition? chronic
Did the patient screen as Food Insecure in a recent hospital admission? No
Does the patient have a high risk readmission diagnosis? Yes
If yes, which diagnosis? COPD;CHF
Does the patient have a primary care provider? Yes
Is the patient drinking an Oral Nutritional Supplement? Yes
If yes, how much is the patient consuming? 100%
How often? 3 per day
Does the patient receive government assistance/utilize community resources? Yes
If yes, what type? SSI/disability
Does the patient need Nutrition Intervention? Yes
If yes, what type? Food Assistance; Nutrition education; Oral Nutrition Supplements
Who was present during RD visit? patient;family

Follow-up Clinical Outreach RD

Row Name 05/28/19
1329
Follow-up Clinical Outreach RD
Which follow-up visit is this? 90 day
Is the patient still malnourished? No
Has the patient implemented recommended nutrition interventions? Yes
If yes, what type? Nutrition education
Has the patient utilized recommended community resources? No
Does the patient have any signs of a nutrition-related complication from last visit? Yes
If yes, In what area improved?

Does the patient have nutrition-related symptoms visit?
Malnutrition Transitions of Care: Outcomes

“I feel like the whole hospital is behind me!”

“It’s so nice to know people are working to help me”

“I’m glad someone is paying attention to my family”
Malnutrition Transitions of Care: Outcomes

MTD 30-day readmission rates

<table>
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<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Cause</td>
<td>11.63%</td>
<td>11.17%</td>
<td>11.25%</td>
<td>11.27%</td>
<td>11.48%</td>
<td>10.53%</td>
<td>11.31%</td>
<td>9.81%</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>23.33%</td>
<td>25.56%</td>
<td>21.43%</td>
<td>20.35%</td>
<td>16.78%</td>
<td>14.20%</td>
<td>15.78%</td>
<td>16.67%</td>
</tr>
</tbody>
</table>

National Average Malnutrition Readmission Rate
Malnutrition Transitions of Care: **Outcomes**

2019 Post-Discharge Hospital Utilization: Intervention Group vs. Control Group

<table>
<thead>
<tr>
<th>Utilization Type</th>
<th>Control</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Encounter</td>
<td>66%</td>
<td>76%</td>
</tr>
<tr>
<td>ED Charges</td>
<td>65%</td>
<td>86%</td>
</tr>
<tr>
<td>Inpatient Encounter</td>
<td>75%</td>
<td>88%</td>
</tr>
<tr>
<td>Inpatient Charges</td>
<td>74%</td>
<td>92%</td>
</tr>
</tbody>
</table>
Malnutrition Transitions of Care: Outcomes

NHRMC Implements Program to Help Malnourished Patients after Discharge

February 18, 2019

New Hanover Regional Medical Center’s Nutrition Services team is implementing a program to help malnourished patients bridge the gap between the hospital and home, ensuring they receive the necessary support to maintain a healthy diet.

The program, known as the Malnutrition Transitions of Care (MT2C) program, was implemented in January and will continue throughout the year.

The program involves a comprehensive approach to identifying and addressing malnutrition in patients. It includes nutritional assessment, education, and follow-up care.

The MT2C program was designed to address the challenges of malnutrition in the hospital setting and to ensure that patients receive adequate nutrition before, during, and after their hospital stay.

Through this program, the Nutrition Services team aims to improve patient outcomes by reducing hospital readmissions and improving overall health outcomes.

The MT2C program includes ongoing patient education and support, as well as close monitoring of patient progress. This approach helps patients make healthy dietary choices and manage their nutrition needs effectively.

The program is a collaborative effort involving the Nutrition Services team, as well as other hospital departments and community organizations.

By implementing the MT2C program, New Hanover Regional Medical Center is taking a proactive approach to addressing malnutrition, ultimately benefiting the health and well-being of its patients.

For more information on the MT2C program, please contact the Nutrition Services team at New Hanover Regional Medical Center.
Malnutrition Transitions of Care: Cancer Center

ZCC Food Box Initiative

- ZCC Dietitians and Social Workers identifying Food Insecure patients undergoing cancer treatment
- Over 60 boxes have been distributed to date
- 50% of Oncology patient receiving food box are also malnourished
Malnutrition Transitions of Care: Next Steps

❖ Continue reinforcing all key steps in the identification of malnourished patients (nursing screen, MD documentation, RD continuous training)

❖ Expand Clinical Outreach RD staff to incorporate other disease states and/or patient populations

❖ Spreading the word…continue educating staff / providers and sharing with other organizations across the country.
Thank you for your time! Questions?