

TEAM-BASED NUTRITION CARE STRATEGIES FOR OUTPATIENT QUALITY CARE

Featuring :: Francis Colangelo, MD & Ezz-Eldin Moukamal, MD

TRANSCRIPT

Maura: Let's start today's podcast episode with some details I've pulled from today's experts. For instance, did you know that in the United States today, 25-30% of adults living in the community are at risk for poor nutrition? Even so, poor nutrition is often undiagnosed and under-treated in the outpatient setting, which can lead to less-than-satisfactory patient outcomes and, of course, higher medical costs.

I **Maura:** I'm Maura Bowen with the Abbott Nutrition Health Institute. On today's podcast episode, we'll discuss population health strategies in general and talk about how a set of very specific strategies helped Premier Medical Associates to identify and combat poor nutrition faster and more effectively. Now, if you're not familiar with Premier Medical Associates—or, that's PMA, if you'd like—it's a health network out of the Greater Pittsburgh, Pennsylvania area.

Maura: Joining us from PMA are Chief Quality Officer Francis Colangelo, MD, and Chief Medical Officer Dean Moukamal, MD. Both are here to tell us a bit about some changes PMA leadership put into place to promote good nutrition and elevate the dietitian's role in optimizing care. Dr Colangelo, Dr Moukamal, thanks for joining us today.

Maura: Let's start with some proper introductions for you both. Would you mind telling us a bit about yourselves: Your names, current roles, and backgrounds? Dr Colangelo, would you like to go first?

Dr Colangelo: Sure, thank you for having us today, Maura. I'm Frank Colangelo, I'm an internist at Premier Medical Associates. I've been here for a long time—over 30 years. I practice half-time as an internist and half-time helping the practice with some administrative work. My passion is serving as the Chief Quality Officer of the practice, always looking for new and innovative ideas that can help improve the health of the patients we serve.

Maura: How about you, Dr Moukamal?

Dr. Moukamal: Thanks for having us on the podcast. My name is Dean Moukamal. I'm a practicing hospitalist...board certified and moved into a hospital medicine somewhere 15-20 years ago. I've been with Premier Medical for about 13 years now, since 2007/2006, and currently I serve as the Medical Director of the hospitalist program and am currently the Chief Medical Officer at Forbes Hospital.

Maura: Can you tell us a bit about Premier Medical Associates?

Dr Colangelo: Premier Medical Associates has been around for about 25 years. It's a 100-provider multi-specialty practice in the eastern suburbs of Pittsburgh, Pennsylvania, equally split between primary care and specialty. Premier is noted as being one of the highest-performing practices, both locally in our market regionally, and we've had some national recognition for the work that we've done in improving the health of patients.

Dr Moukamal: We have 24 specialties and 10 locations in the greater Pittsburgh area. We serve over 70,000 primary care patients, of whom 32% are over the age of 65. In 2018 actually, we had about 377,000 patient visits across all our service areas. We have won multiple awards from the AMGA, including an Acclaim Award and also from Optum for innovation in population health, and we are very proud of that.

Maura: We're here today to talk about some of the innovative population health management strategies PMA has introduced to its outpatients over the past few years. First, to level-set, how would you define the term "population health?"

Dr Colangelo: There are several parts to that definition. When we first started on this journey about a decade ago, we used the [idea of] not just taking care of the patients that are right in front of us but taking care of all of the patients that we should be seeing and meeting their healthcare needs. And I think that evolved over time into trying to implement programs that can enhance the health of a large population through excellent healthcare delivery. Some population health experts say only about 15-20% of medical issues are amenable to medical care. There are many social determinants of health that can also be involved—where people live, where they work, where they play, and you know their availability for healthy food—that can affect their outcomes over time, also. So, it's a pretty complicated answer.

Maura: You've been in the innovation business for a while. Can you tell us a bit about some of the population health strategies you've created at PMA?

Dr Colangelo: People oftentimes ask us what is our secret sauce. What is our secret to success. And I think I've boiled it down to three big buckets that we've tried to work very vigorously to improve the health of patients. Number one is we want to take things such as *** cancer screening, colon cancer screening—diseases that are amenable to a screening—so that you can catch things at an earlier stage and help to improve patient outcomes. Diseases that can be prevented through vigorously immunizing patients. Chronic diseases—if we better control patients who have diseases, such as diabetes and heart hypertension, we can improve those patients' outcomes. And then we've also gotten into using some advanced analytic population health tools that can help identify patients who require more intensive support and care coordination. So, we sort of have a three-pronged approach: prevention, better managing, and identifying those patients who can benefit the most from more intense help.

Dr Moukamal: As Dr. Colangelo has pointed out regarding some of the strategies we've implemented, many of the strategies cross the spectrum of care, including inpatient care. Many of those strategies involved a management of the patient throughout their stay and actually addressing any other issues that may be found during the hospitalization and making sure there's a safe transition for those patient-to-outpatient facilities. Many of those strategies have been improved over the years to try to improve any gaps in care.

Maura: Before PMA decided to address nutrition as part of its population health strategy, what were some of the challenges your team and your patients were facing in the outpatient setting? What were some of the gaps or disconnects?

Dr Colangelo: I think I'll answer it in a way that's sort of across both the outpatient and inpatient world. For all of the successes that Premier has in terms of managing diseases, you know, getting the highest-quality scores on pay-per-value programs from the local insurers, the one thing that has been a problem that we have not been able to do a tremendous job with is preventing patients from being admitted to the hospital and preventing patients from being readmitted to the hospital in their early state. So there was something about what was something that was going on in the transition period, from patients leaving the hospital coming into the outpatient world, assuming here that we were falling down and weren't providing the best care possible for those patients.

Dr Moukamal: One of the things we've seen during the hospitalization is the patients who have poor nutritional status tend to have higher readmission rates, frequent utilization of services, longer hospital length of stay, with

also, unfortunately, poor outcomes. That led us to think about what other things we could do to help us close these gaps.

Maura: What was the catalyst for deciding to more aggressively identify poorly nourished patients?

Dr Colangelo: Maybe two or three years ago I was at a national meeting and was sitting next to an Abbott Nutrition rep who asked me as part of conversation, had I heard about some of the work that the Advocate Medical Group in Illinois was doing to help to improve nutrition for hospitalized patients, and the fact that it had reduced the risk of those patients who had some nutrition interventions performed to reduce the risk of them being admitted to the hospital or readmitted to the hospital. And that greatly piqued my interest. I remember turning to Dr Moukamal later that same day, saying we need to talk more about this to see if there's something we can do to make a difference for our patients.

Maura: That's great to hear! And for our podcast listeners, we actually did a podcast episode on that group [["Reducing Hospitalization & Costs on Home Healthcare – A Review of Advocate 2.0"](#) with Jamie Partridge, PhD, MBA]. So if you'd like, you can listen to that podcast just by finding the link in the transcript below. Thank you for mentioning that Dr. Colangelo.

Dr Colangelo: You're welcome.

Dr Moukamal: In general, nutrition has been gaining momentum across the healthcare industry in terms of control in some of the poor health outcomes, and during our interaction with the teams, especially some of the work we've done locally with the group, and working with the apps on Advocate, we've found that there are things we can do to address those that haven't been done in the past. We thought, "It's the right time to do that."

Maura: Can you tell us how patient nutrition is addressed for transitional care patients?

Dr Moukamal: When a patient reaches a facility and wants to be admitted, there's a nutrition screen that happens, usually triggered by a nursing team, and that can actually dramatically trigger a dietary consult. When the dietitian sees the patient, she will make a specific recommendation to the provider to address some of the additional gaps the patient may have. And we have relied on that process heavily to try to identify those patients, in addition to identifying the BMI and any issues that may indicate there's a nutrition gap or a deficit that has to be addressed for that patient before they leave the facility.

Dr Colangelo: Our typical protocol when patients are discharged from the hospital, we find out about this within 24 hours. And within the first 24 to 48 hours our nurse navigators—that's what we title them in our office—do an outreach telephone call to those patients, making sure that the patients' symptoms are controlled, confirming that they're on the correct medications, asking if they have follow-up questions—but then they also have a standardized series of questions that we have implemented, helping them to identify those patients who might benefit from more intensive nutritional support. And those notes are documented in the electronic health record so that when that patient comes in several days later for their follow-up visit, they can talk to that patient in a more one-to-one setting and tell them about the available options for improving their nutrition.

Maura: So, clearly, in order to roll out an initiative this large, you have to get support from both senior leadership and clinicians? Whose approval and support did you need, and how did that go?

Dr Colangelo: Well, Dr Moukamal and myself are sort of part of the senior leadership and clinicians, so when the two of us got excited over the prospect we turned to our Director of Quality, Holly Hearn, who is a nurse who is in charge of the nurse navigators, and asked her to listen to this, and she quickly bought in. And then it was brought to the attention of the rest of our administration and board that we were going to be working on this project. The fact that Dr Moukamal and I were passionate about it from the beginning made it a very easy sell for the rest of our

executive administration.

Dr Moukamal: Luckily, we have a very forward-looking leadership, both at Premier and also at the facility that did recognize that poor nutrition is a major determined for those patients and should be addressed. So we were actually lucky enough to have the support of the leadership team and diligent work from the dietary part to take a lead on that. In addition to working with the IT teams to try to get all the changes necessary to address those gaps.

Maura: Can you tell us what steps you took to prepare for, launch and execute the initiative, and how long it took?

Dr Moukamal: As I said earlier, we already had some steps in place to try to get this initiative going, but we really needed to build it from the ground up to make it sure it's a consistent process across outpatient and inpatient. So some of the steps we took on the inpatient side, including the adjustment of identification of patients, including and giving additional responsibilities to the registered dietitians, to be able to make changes to diet order and able to add nutritional supplements as necessary without having really to go back to the physician and delay that process or create an any obstacle in the way. That took us a little time to try to get the policy in place. So the main thing was trying to adjust the policies and to have all the necessary regulation in place. When that took place, from there it was easier to get the initiative going and to continue to build on that momentum.

Dr Colangelo: I mentioned Holly before; she became passionate about this, and within several days had the note form in the electronic health record. She built that with the questions—the screening questions that were appropriate. And within the next week, had sat down with the seven or eight nurse navigators that were working at that time, explaining why this is going to be part of their transition of care telephone calls that they make. So, it was not very time consuming. Within an hour, she had the note form written, and within a week, we had a staff trained, and the screening was being done a documented in a pretty robust manner.

Maura: That sounds fairly smooth. And you've mentioned the nurse navigators now a couple times, so I wanted to ask about the multidisciplinary team. Clearly it played a significant role in enacting your initiative, so I'm wondering if you can speak to that for a moment?

Dr Colangelo: At the beginning whenever we have a nurse navigator, there were some providers that, you know, weren't totally into the whole team-based care. You know, "I am the doctor. I'll take care of everything. You...I'll...You...You do what I tell you to do." Well there's been a culture shift over the last five to six years in the practices. All of the providers realize the tremendous job that our nurse navigators do. During our morning huddle, that I can do once or twice a month I'll have a nurse navigator say, "Mrs. So-and-so is coming in for her post-hospital visit. I did a screening, it's abnormal, I want to spend time with her today talking about nutritional support." So, it's become just part of the standard workflow on these patients. Every doctor in the practice is excepting of it right now because they realize it's the right thing to do.

We were fortunate as part of the multidisciplinary team at Premier that we have pharmacists, we have medical social workers, behavioral health specialists, and we have a full-time dietitian who works for us in the practice. The nurse navigator points out someone requiring even more assistance and will get them involved. I know it's a valuable part of our multi-specialist team.

Dr Moukamal: The significant bulk of work obviously had been done by the nurses and dietitians in this regard, also working occasionally with the pharmacy team as well. But merely working also with the IT team and even the regulatory team to try to make sure we're able to do some of these changes—especially on the inpatient side—that lead us to making the necessary changes to the policies and also put these policies in action through HR.

Maura: You mentioned that culture change was a challenge for rolling out the initiative. Where there other challenges you faced, and also, what went more smoothly than you expected?

Dr Colangelo: See, I think the whole process went more smoothly than we expected. I don't know that there were

any major challenges. You know, I was amazed when, you know, Holly took this and ran with it and had everything built, and had our staff trained as to what to do, and bought into why it was an important thing to do. So, the entire process went tremendously smooth—much better than I thought that it would.

Dr Moukamal: The main thing, challenges-wise, was really the regulation and adjusting the policies. That usually takes a little longer-term, and usually required the approval of the medical executive committees, but that was smoother than I expected. I think everyone realized the need. And once those changes took place, things rolled very easily from there.

Maura: You mentioned training and education. Can you speak a little bit more about what that process looked like to ensure that the initiative was being prioritized and that the multidisciplinary team was adhering to the recommendation on the nutrition regimen?

Dr Colangelo: We're fortunate. About once a quarter, all of the adult primary care doctors in the practice will come together for a combined primary care meeting, in which we'll talk about upcoming initiatives. Within a few weeks of this kicking off, we explained to the doctors—myself and Dr Moukamal—what was happening, why it was happening. We shared some of the Advocate data with the providers and told them this was going to be something that was mostly going to be implemented by the nurse navigators and by the dietitian of the practice when required. But, yeah, it was a very easy buy-in. I think most of the providers realized this was something that made sense and wasn't going to take a large amount of their time because the rest of the team was going to be taking it off their plates.

Dr Moukamal: On the inpatient side, we did work with the clinicians to share the changes that were made to the policy, the importance of these changes, and why it was important for the clinician to ask nutrition status on admission and discharge. We spread that message by mass communication but also we provided specialized education through the physicians that are responsible for the majority of the patients in the hospital, specifically hospitalists, and clinicians who have large services, such as the trauma team, such as the private practice program to ensure that clinicians understand the vital role the clinician plays in these patient outcomes.

Maura: I wanted to ask: How do you plan to assess the impact of your transitions of care initiative?

Dr Moukamal: Like any other initiative, we started with the issue of what patients had suffered from, which is unfortunately a higher admission rate, longer length of stay, and occasionally we'll have an undesirable outcome with frequent returns and frequent use of services. So we want to use some of these metrics to see if we've made any success in that. Especially when the patients had been earlier identified at risk. And if we're able to address those gaps, have we been able to impact the readmission rate, the utilization rate and also their hospitalization rates. In addition, preventing any outcome that may be directly related to poor nutrition—that's going to be one of the things we'll look at.

Dr Colangelo: We were involved with our largest insurer in the market with a risk contract and we're tracking at this time the total cost of care—we're tracking admissions; we're tracking readmissions—we're not going to see success overnight, but I would hope that over a year, or year-and-a-half, or two years, that we're going to see improvements in all of those metrics. And what part will this added nutritional support play in that? If I'm not able to tease out exactly how much it did, I'll just be happy to see improvements in those metrics we're following. I think that this will have played a large part in that.

Maura: I know that you've had some early successes but looking back what do you think has been key so far to those successes?

Dr Moukamal: I think the key to success is the buy-in from the clinician, from the administrative team, and from the

group in general—making sure that this project is successful, this initiative is as successful as possible, because it does definitely impact patients in any spectrum of care.

Dr Colangelo: The fact that Holly was so supportive of it as soon as Dr Moukamal and I introduced her to the concept, that she was able to take it in a quick period of time have the note and have her staff...the fact that it didn't take months and months and months for us to implement this that is our largest key for success.

Maura: To bring it all home for our listeners, what learnings from this initiative can or should clinicians apply to their practice?

Dr Colangelo: It's important to screen patients for nutritional deficiencies, and it does not take a large amount of your time or your care team's time. I mean, the patients need to be screened whenever you find that there's a problem. It's easy to offer them solutions for improving their nutritional status.

Dr Moukamal: I think the main thing we've learned from this is that there's always an opportunity to improve patient outcomes. Some are clear, some are not. Nutrition in that case has not been a primary source of concern for many of our clinicians, but once that initiative took place, that became a little bit more in the forefront, and people have paid more attention to it. And also having specific steps that can be followed, and things that can be done to address these gaps—that made it easier.

Maura: And it seems like this initiative has the opportunity to grow. Do you see an opportunity to benefit other patient populations beyond transitions of care, and if yes, how?

Dr Moukamal: Yeah, I think in general the elderly population are at risk, and there are many patient populations that may not have been historically known to suffer from nutritional deficiencies that can be screened better, can be actually identified better, by more tools or by even questionnaires that can be developed. So I do see an opportunity to take this to a different population group and impact outcomes as well.

Dr Colangelo: I haven't thought of implementing it in other populations—we're always focused on those patients that ended up in the hospital. But I mentioned before that we have our advanced population health tool, and I'm sure that we could use that to tease out patients that are at the highest risk for admission. They may not have been admitted to the hospital yet, but they're at a high risk for admission because of their underlying medical condition. Our nurse navigators are involved with many of those patients on a regular basis to help to keep them well. I guess we could implement the nutrition screening for those patients that are at the highest risk. Thank you for giving me another idea that I'm going to talk to Holly about.

Maura <<laughing>>: Well that's why we're here. Dr Colangelo, Dr Moukamal, thanks so much for joining us today—we hope you'll call in again sometime as you have updates.

Maura: And for you, listeners—thanks for joining us today. As a parting gift, we've provided a printable case study outlining some of the things you've heard today, in case you'd like more information. You'll find [the link to this handy document](#) in the transcript for this interview.

Maura: Thanks again. Looking forward to catching up again on our next episode.