MQii SUPPLEMENT TO THE SEPTEMBER JAND

Featuring :: Ainsley Malone, MS, RDN, LD, CNSC & Albert Barrocas, MD

TRANSCRIPT

Maura: Hello, and welcome to the Abbott Nutrition Health Institute podcast. I’m your host, Maura Bowen, and I’m here today to kick off a five-episode podcast series featuring Malnutrition Awareness Week, a campaign born of the American Society for Parenteral & Enteral Nutrition—that’s ASPEN to you. The campaign has been around since 2012, and it’s starting to enjoy some global reach this year thanks to the Canadian Nutrition Society (CNS) and the British Association for Parenteral & Enteral Nutrition (BAPEN).

Maura: Obviously, malnutrition is a hot topic here at ANHI. It’s also a huge topic, and so we spent a lot of time as we were planning this series trying to determine where to even start that conversation. We decided to go big by digging into the Malnutrition Quality Improvement Initiative (otherwise known as MQii)—what it is, how it got started, the impact of the program, and why it’s so important to have “all hands on deck” when it comes to implementation across the continuum of care.

Maura: With that said, allow me to introduce none other than WellStar Atlanta Medical Center’s now retired Chief Medical Officer and honorary member of the Academy of Nutrition and Dietetics since 1993, Dr Albert Barrocas, along with the esteemed and highly credentialed Ainsley Malone (MS, RDN, LD, CNSC), who was president of ASPEN in 2013 and is a long-time friend to ANHI. Ainsley, Dr Barrocas, welcome. We’re thrilled to speak with you today.

Maura: First, of course, proper introductions are in order. Can you each tell us a little bit about your backgrounds and current roles? We’re also always interested to know: Why nutrition science? What drew you to this field? Dr Barrocas, would you like to go first?

Dr Barrocas: Thank you, Maura, and the organizers of Malnutrition Awareness Week. I’m a retired surgeon and administrator having gone to Emory University School of Medicine in undergrad and two years of residency there. Prior to entering the Air Force, where I completed my general surgery residency. I’m certified in surgery and performed general, vascular, non-cardiac thoracic surgery and nutrition support for over 30 years in New Orleans in Louisiana, primarily. Following [Hurricane] Katrina, I then pedaled back into Atlanta, where I was the Chief Medical Officer and Vice Medical Affairs for the Atlanta Medical Center’s two campuses. I’m a fellow of the American College of Surgeons, and I’m a fellow of the American Society of Parenteral and Enteral Nutrition and have been a charter member of ASPEN since 1977.

Maura: Excellent, thank you. And how about you, Ainsley?

Ainsley: Thank you, Maura, for the great introduction, and I too am very thrilled to be participating in today’s inaugural Malnutrition Awareness Week podcast. I’m a masters-prepared Registered Dietitian Nutritionist. I have been a nutrition support dietitian well over 30+ years. I’m a certified nutrition support clinician. I work in an academic teaching hospital in the Columbus, Ohio, area and have been in that healthcare system for over 30 years. I’m a fellow at the Academy of Nutrition and Dietetics, and like Dr Barrocas, a fellow with the American Society of Parenteral and Enteral Nutrition. I’m also currently a clinical practice specialist with ASPEN as well.

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Maura: Dr Barrocas, let’s start by digging into some of the baseline details about malnutrition. Clearly, we all know malnutrition exists, and that there are many, many people around the world who are affected by it and need help—but for the record, how do you define malnutrition?

Dr Barrocas: Well, Maura, I go back to the basics and “mal,” means “bad.” So for me, malnutrition refers to the lack or excess of needed nutrients, respectively. Now, my personal interests have been primarily concentrated in undernutrition as it relates to protein and calorie deficiencies.

Maura: Ainsley, why should we look at malnutrition as being of particular concern for older adults?

Ainsley Malone: Well I want to echo exactly Dr Barrocas’ definition and would like to really highlight the critical aspect of malnutrition in the older adult as you mentioned. We know that individuals who are 65 years old or older are more likely to have one or more chronic diseases or comorbidities, which really can increase their likelihood of becoming malnourished. We know negative outcomes, including higher healthcare costs, higher incidences of complications and even higher mortality are more frequent in malnourished older adults compared to those who are normally nourished.

Dr Barrocas: And I would echo what Ainsley just said, in that we have to remember that 50% of older adults have a caregiver who is also an older adult, and that impacts the social determinants of health in that population.

Maura: In what way? Can you expand on that a little bit?

Dr Barrocas: In that the caregivers themselves are experiencing comorbidities and some disability, and they’re trying to keep their loved one at home. And it is, I would say, a risk factor for malnutrition in the elderly.

Maura: Thank you for clarifying. Now: How did each of you become involved with the issue of malnutrition in your own careers?

Ainsley Malone: Maura, over my many years of practice, I’ve seen a number of instances of patients who actually became malnourished during their hospital course, and I was actually able to see it—see how that malnutrition greatly impacted their lives. Malnutrition actually is something we’ve known for over 40 years, in the first landmark publication by Dr [Charles E] Butterworth [Jr] that was published in the 70s [1974] on “The Skeleton in the Hospital Closet.” That was really bringing forth the recognition that malnutrition exists in our healthcare setting. And even though we’ve recognized it for that period of time, we’re still dealing with the same types of prevalence that we were experiencing back then. So I’ve really become a stern advocate to improve how we address it in the healthcare setting so that 40 years from now—I certainly won’t be practicing—but hopefully this still won’t be such a big issue as it is now.

Dr. Barrocas: My interest in nutrition began as a fourth-year medical student, when I was making rounds with our endocrinologist, primarily rounding on diabetic patients, and some interest in obesity. I did some early work with jejunal-ileal bypass before there was gastric bypass surgery for morbid obesity. But my epiphany, if you will, took place in 1970 as a 2nd-year surgical resident, when I was exposed to the development of this whole technology called TPN—total parenteral nutrition, now—but before that, hyperalimentation. I through the years had seen many, many patients survive catastrophic illnesses and catastrophic surgeries, only to die of the inability to provide adequate nutrients that they needed for their recovery through this experience. And so I became a fan of the technology; I became very engaged in ASPEN and other avenues to improve my education, since I did not have formal education in nutrition, as most of my colleagues also experienced the same.

Maura: What specifically is the Malnutrition Quality Improvement Initiative and how is it bringing increased focus to the issue of malnutrition?
Ainsley Malone: The Malnutrition Quality Improvement Initiative—or as you’ve heard, MQii—is really an initiative to advance high-quality care for our patients who are malnourished or are at risk for becoming malnourished. It was developed several years ago by multiple key stakeholders in the malnutrition arena, including organizations such as the Academy and ASPEN. It was really developed to address and advance nutrition care in our healthcare environment, to really promote quality nutrition care across the board so that gaps in quality malnutrition processes could be assessed and then addressed.

Maura: You’ve touched on some of the objectives of MQii. Can you tell us about some of its tools?

Ainsley Malone: The MQii offers a really robust toolkit which provides tools and resources using a two-pronged approach to help organizations understand where they are in terms of malnutrition care best practices and guides them to identify what opportunities they may have from a quality improvement perspective, and really identify some of the key critical gaps in how the assess malnutrition, how they document malnutrition, how they intervene with malnutrition, and then how those individuals who are malnourished—how that information is carried on when they are discharged from the hospital. In addition, it also offers a set of malnutrition electronic clinical quality measures to assess the current body of care at their own facility and really allows them to monitor changes over time as they utilize the quality improvement process, which is I think is a really great way for facilities to assess where they are, and how they can improve and work toward that improvement.

Maura: How has MQii brought visibility to the nutrition care process?

Dr. Barrocas: Well to amplify on what Ainsley just stated so eloquently, the development of the toolkit, and the fact that you have hundreds of hospitals firmly participating in this collaborative effort in a very synergistic fashion, will lead to the early identification, diagnosis and documentation of malnutrition. The old adage is that you cannot treat what you cannot diagnose. And for many years, including today, our patients are dying of consequences of malnutrition, because of many factors, including education in the undergraduate level, lack of robust required education of nutrition in residency, etc. Nutrition is not a core specialty, so there are very few individuals who have dedicated themselves to nutrition. And certainly, what the MQii has afforded is the dual-pronged approach Ainsley alluded to, which provides the vary basic tools that can be incorporated into the day-to-day management of these patients and of the individuals that are in the community—it doesn’t have to be the hospitalized patients. You know we need to shift from rescue and repair medicine to health promotion and disease prevention. And this initiative, the MQii, is just one of the answers to address those issues, so that we have the ability to identify at risk patients through screening—that’s one of the electronic clinical quality measures (ECQMs). We have the ability then from that within 24 hours to diagnose or at least establish criteria that leads to a diagnosis that has to be documented in the medical record by the physician, and then a treatment plan an intervention that not only addresses the needs while the patient is in the hospital, but also poses the fourth element, which is that of discharge planning and post-hospital discharge nutrition. May times, the impact of nutrition intervention cannot be realized because the length of stay is about 5 days, and it takes 2 days to complete the nutrition screening and nutrition assessment with the appropriate diagnosis. Then there’s very little intervention that can be effective while the patient is in the hospital.

Maura: Those are excellent points, and I’m so glad you made them, because they’re a perfect segue, too, into the next question for Ainsley. Ainsley, in your mind, how has MQii helped patients improve their outcomes?

Ainsley Malone: We certainly know and we’ve alluded a little bit already the negative outcomes that malnourished individuals experience. What we’ve seen through the MQii, what we’ve seen some of the publications that have been authored by participants in the learning collaborative—those who have utilized the MQii toolkit and resources to address malnutrition in their facilities have been able to demonstrate improved patient outcomes. And these have primarily been related to reduction in hospital length of stay, which also we know reduces hospital costs, and also there’s been some demonstration that 30-day hospital readmissions have also decreased in those facilities that have utilized MQii toolkit and resources. And we know that both of those are increased in malnourished individuals. And, specifically with the 30-day readmissions issue, as we know, CMS does not provide reimbursement for that
Ainsley Malone: And also with the volume-based purchasing, there are many conditions that while not specifically related to nutrition, are definitely impacted—such as surgical infections, pressure sores, falls, etc., that have clearly demonstrated a linkage to a poor nutritional status. In one study, I think it was 44% of the readmissions, for instance, were attributed to lack of proper nutrition—in other words the nutrition status of the individual declined post-discharge.

Maura: I understand that The Academy of Nutrition & Dietetics recently released a special MQii supplement to the September Journal of the Academy of Nutrition & Dietetics. I think that supplement features articles and abstracts that highlight the impact of malnutrition quality improvement on interdisciplinary patient care and clinical nutrition practice. So, Ainsley, how and why did this supplement come about and what has been your role in the creation of the supplement?

Ainsley Malone: Thanks, Maura, for this question. I think it was really exciting when this idea came forth. And the idea was really to bring together all the great efforts and work that has been done by those facilities that are part of the MQii learning collaborative, and how they’ve been able to elevate malnutrition care in their facilities. I think having this kind of central stage, so to speak, for the articles and the abstracts. And not all the articles are from the learning collaborative participants…but those who were integrally involved in the development of MQii, and the overall, overarching quality improvement approach, I think really provides a great background on the whole malnutrition quality improvement initiative process. Also having the articles from those clinicians who have implemented quality improvement activities using the MQii is really a great opportunity for others to learn how they may be able to address malnutrition quality care in their facilities. My role in the supplement is the same as Dr Barrocas—we were two of the three overseeing editors for the publication.

Maura: Can either of you give us some specific examples that demonstrate MQii’s success?

Dr Barrocas: Well I can give you about three of them that come to mind, and the first one being the VHA system, which is the Veteran’s Health Administration, and within that, their nutrition and food services—or NFS—department that started the strategic goal in 2014 trying to increase the ability of dietitians to do some bedside assessment based on the…consensus of AND & ASPEN. And by the end of the year 78% of dietitians had completed the training. The bottom line is that adoption of that methodology reached a lot of veterans, and actually 14,000+ veterans were identified as malnourished with the new coding system. That increased after 2016 that 30% are using the ICD-10 codes—more than 77,000 inpatient and outpatient veterans have been identified with malnutrition. The second one of course is the MQii itself, that in 2017, through the learning collaborative increased malnutrition diagnosis rates among patients—older adults—by 19%, and in 2018 reported an additional increase of 24%. And the third example was actually cited by secretary Alex Azar of an Illinois-based health system, who’s quality improvement program assessed translated to a cost savings of $3,800 per patient in the acute setting.

Maura: Those are amazing statistics, and I think that they’re the perfect segue into the next question I have for you, Dr. Barrocas: How have HCPs—or healthcare professionals—benefited from the initiative? We’ve talked a bit about patients, but I’d love to know about how practitioners are seeing the benefit.

Dr Barrocas: Before I answer that, I’d like to expand on one aspect of your prior question, which is that there are many other examples of success in the MQii process, included in the supplement. In addition to the core articles—and the lead article is also co-authored by Ainsley and myself—there are many abstracts of various aspects of MQii and quality improvement.

Dr Barrocas: Now to the question of how health professionals have benefited, I would say that we have been able to
provide evidence in data at the local level and at institutions that demonstrate the benefit of adequately and timely identifying, documenting, intervening...malnutrition and the impact that it has improving quality and financial methods and outcomes. And this is in tandem with the changing landscape of the healthcare environment where we’re shifting from just measurements to actual outcomes that are quite palpable.

**Ainsley Malone:** There are some additional examples that I can share, and many of them are included in the supplement. There are many abstracts that highlight some of the specific successes that participants who are utilizing the MQii toolkit have been able to demonstrate, and some of them focus on what Dr Barrocas mentioned—improve malnutrition documentation. And actually, one abstract focused on how they were able to increase their hospital cases index, which we know is so important to really help capture the higher acuity of care these patients require and it’s really something that is important so that hospitals financially can obtain resources to care for these patients. Our one particular abstract focuses on how using the MQii toolkit allowed their facility to increase the accuracy of diagnosing malnutrition using the nutrition-focused physical exam. Additional abstracts have focused on how facilities have been able to reduce hospital costs and length of stay as I mentioned previously.

**Maura:** Great, thank you. So you both have alluded to this a little bit already: It sounds like MQii programs are most effective when all hands are on deck, so to speak—in other words, when all members of the care team are aligned with and involved in its implementation. Why is program support and interdisciplinary involvement so important here, do you think?

**Dr. Barrocas:** I think because it provides synergy. The fact is that clinicians did not share in the same goals as administrators, and vice versa. We need to understand others in order for us to be understood. And to that, I’m a champion of trans-disciplinary—that is the concept of—concentrating on function rather than on form, and utilizing the best available individual to perform a particular function, regardless of their specific discipline. In other words, working as a cross-functional team the outcomes are greater than the sum of its parts.

**Ainsley Malone:** Yes, and I would just add to that addressing malnutrition in our hospitals really takes a village. We have the responsibility of {inaudible}...I know that early in my practice there wasn’t really the concept of, as Dr Barrocas said, trans-disciplinary healthcare. It’s really important that every member of the healthcare team has a role in preventing and treating malnutrition. I think also having buy-in from the hospital’s leadership is essential. And the toolkit really offers a great number of resources to help facilities obtain that buy-in from their administrators.

**Maura:** Now. Let’s talk about involvement, then, since it’s so important to have all hands on deck. Here at ANHI, we love a good call to action, and so do our listeners. Can you give advice on what steps can they take to help improve malnutrition identification and treatment in their own institutions?

**Dr. Barrocas:** Well, I think first of all, individuals need to become thoroughly familiar with MQii, its tools, the toolkit, and the results to date. And I think, for those who have not participated previously, a review of the very fine supplement that has just been published in September is a great beginning. Also, individuals that they may know, throughout the country or through the various associations, are a great resource. And then, once you have that basic knowledge of what’s available, then to get others involved, remembering that in order for me to be understood, you first must understand, and have the data that is needed in a particular environment. So when you talk to a physician, you’re going to have a different approach than if you’re talking to, say, a VP of a pharmacy, or the VP over a food service, or the other members of the C-suite.

**Dr. Barrocas:** I think it’s important to identify a champion that really feels the same way you do about malnutrition or certainly is someone that understands, accepts and learns from what you can provide that individual. But having a champion will allow you to really become successful, because again it takes a village, compared to just one individual trying to move the needle, so to speak.
**Maura:** Perfect. Thank you both. I know it’s time to wrap, but before we go, do you have any parting words or additional advice for our listeners today?

**Dr Barrocas:** Stay or get involved, be a protagonist, and remember that one individual can make a difference. Ainsley Malone - My parting advice is to begin small, and by doing so, you can really grow in your efforts and achieve great things. Sometimes, just starting small really kind of allows you to become comfortable and familiar with the work you’re doing, and really addressing one small component of these processes will lead to greater focus, increased scope, and really leading to an overall major improvement in the care provided to your patients.

**Maura:** Excellent. I think that’s excellent advice and a great recap today. Before we sign off, I wanted to offer a quick side note for our listeners: You can access this MQii supplement on anhi.org from our RESOURCES landing page, or by simply scrolling through the transcript for this podcast, and accessing the link that way. And while I’m at it—if you’d like to learn more about MQii and get quick access to all its tools and resources, we’ve made that super easy for you, too. Simply go to anhi.org and click the link that says “MQii” at the bottom of any page on our site.

**Maura:** Dr. Barrocas, Ainsley Malone, thanks so much for your time today, and for sharing your expertise. You’re welcome on this podcast anytime, of course, and we so appreciate you dialing in today. Thank you.