MALNUTRITION PROTOCOL PROGRAMS AT LEE HEALTH IN FLORIDA

Featuring :: Heather Wayco, HMA, RDN, LDN

TRANSCRIPT

Maura: Welcome to the Abbott Nutrition Health Institute podcast. I’m your host, Maura Bowen, and I’m excited to present Episode 3 in our five-episode podcast series on Malnutrition Awareness Week. If you’re unfamiliar with this week-long national observance, it’s a multi-organizational campaign from the American Society for Parenteral & Enteral Nutrition (ASPEN), and it was established to do three things:

• Encourage healthcare professionals to identify and treat malnutrition earlier
• Encourage patients and consumers to address nutrition status with their healthcare professionals
• Increase awareness of nutrition’s role in patient recovery

Maura: I mentioned I’m excited about today’s episode, and here’s why: Our featured guest knows first-hand what it means to build malnutrition awareness from a grassroots level. Heather Wayco (HMA, RDN, LD/N), Director of Clinical Nutrition at Lee Health in Fort Myers, Florida, is here to take us step by step through the process of building a large-scale, long-term malnutrition program for the Lee Health system of hospitals. Heather, thanks so much for being here.

Heather: Hi, yes thank you for having me here today.

Maura: First, can you tell us a little bit about your background, and how malnutrition became a focal point of your career?

Heather: Yes, I’ve been in this nutrition profession for many years. I started out with a bachelor’s degree in nutrition from East Carolina University and after a few years went back to school to obtain my Master’s in Healthcare Administration. With those combinations I’ve been able to work as a clinical nutrition manager at multiple different hospitals, as well as I did [some] nutrition healthcare sales for a few years. And most recently, I joined the Lee Health team about five years ago as the Director for Clinical Nutrition Department. I’ve always loved nutrition and food and eating, and that’s really what drew me to this profession and has kept me in it for so many years. As mentioned, I’ve been here at Lee Health for about five years, and that’s really where malnutrition came to the forefront in my career. We really started focusing on it here at Lee Health.

Maura: Can you tell us a little bit about Lee Health? It’s the largest healthcare system in South Florida, is that right?

Heather: Yes. We are the largest health system in Southwest Florida, between Tampa and Miami. We have four acute care adult hospitals, one pediatric hospital, as well as three post-acute facilities and additional several outpatient areas in our physician group. We currently have about 1400 beds in the acute care setting, but we’re growing another 350 by the year 2020. So we do have a lot of beds and buildings to help patients in this area.

Maura: We often hear from clinicians who regularly see and treat malnutrition, and desperately want to help, and

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they’re looking for almost a playbook of sorts, to help them build malnutrition prevention, screening and support programs for their own communities. I understand that with your help and the help of some of your fellow clinicians, Lee Health was able to build such a program and really make an impact. There’s a lot to unpack here, so let’s take it step by step.

**Maura:** First, what prompted you to build a program? Was there a specific moment or series of moments that motivated you and your fellow clinicians to put a program together?

**Heather:** Yes, back in 2014, my system director, Larry Altier, received a call from a case manager within the system. They were asking him if there was any way possible that he could help provide food for a patient that was being discharged home. The patient didn’t have any family members; they didn’t have a way to get out to obtain food. But at the time we didn’t have any formal program to provide meals. He was able to assist this particular individual but then really started thinking about—“hey, there are probably other people out there in need.” So he started to investigate what could be done.

**Maura:** As you started to put a program together, what were some of your specific goals?

**Heather:** Initially, our main goal of the program was really to help those people in need of food. After we began the process, we found many more benefits to the program as a whole.

**Maura:** How did you begin? What was that first step?

**Heather:** Larry enlisted one of our dietitians, Julie Cole, at the time to really help to team up with this program. Their first step was how to decide who would get the meals. They really needed some objective data to give some criteria on who would receive the meals, because a lot of times it’s financially based, or not. Around that time, or just after, the consensus statement from the Academy of Nutrition and Dietetics and ASPEN had come out back in 2012. So they had those standardized characteristics for identifying and documenting adult malnutrition. So Larry and Julie decided they would use this criteria as an objective way to determine who would actually get the meals.

**Maura:** As you started to build out the program, it seems as though a variety of components were developed. Can you speak to what those components were?

**Heather:** Sure. The initial pilot study targeted patients that were at high risk for readmission. So they looked at patients with COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure), pneumonia, and acute MI (myocardial infarction). They needed to have the dietitian complete an aggressive nutrition screen and assessment using the malnutrition guidelines. From that, if the patients had two or more of the clinical criteria of malnutrition, they decided that those patients would be eligible for meals upon discharge. At the time the created the Flavor Harvest@Home meal delivery program. And what this is a 28-day meal delivery program. We deliver meals to [patients’] homes for four weeks. They receive breakfast, lunch, dinner and snacks, as well as oral nutrition supplements as needed. This is at no cost to the patient.

**Heather:** And they also created a variety of menus to meet the therapeutic need of the patients. So once they received the four weeks of meals, we wanted to find out what the impact of those meals was on readmission rates, as well as their patient clinical outcomes. So this initial study that they did in 2014 found that patients who received the meals had a lower incident of readmission—at about 25%—compared to those that didn’t receive meals—at 59%. You can see [readmission rates] almost doubled for [patients who] didn’t receive the meals. Additionally, they thought that patients had some good outcomes with the nurse navigator who would see the patients in the home after they received the four weeks [of meals], and they saw improved outcomes as well. They really thought this program could have some cost savings to the hospital by reducing readmission rates, as well as increasing outcomes.
Maura: As you piloted the program, what challenges did you face? Did anything surprise you about the rollout?

Heather: When we received the initial pilot study and came to those conclusions, we were able to pilot at one whole hospital. We knew we had to make a few adjustments to what we did during that initial pilot. We had to hire additional staff—we had a smaller dietitian team at the time—and so with this more comprehensive assessment, we would need more dietitians, because they would be spending more time with the patients at the bedside. We also wanted to look at all diagnoses instead of just those four main ones [COPD, CHF, pneumonia, acute MI] I mentioned earlier. We wanted to open it up to all different patients who may potentially be eligible.

Heather: We did conduct a lot of education with our physicians, and our other clinicians about the program. Many times we would receive requests for meals where the patient didn’t meet the clinical criteria for the program, and that was really hard because the patients may have needed the meals possibly due to financial circumstances, but if they didn’t meet those clinical criteria, we were unable to provide those meals.

Heather: What really surprised us was that there were just so many patients who were at risk for malnutrition. We just couldn’t believe it.

Maura: Knowing what you know now after launching a successful malnutrition program, do you have any advice to offer other clinicians to help them start building programs of their own? Just as importantly, do you have any tried-and-true tactics to gain traction and to help programs become integral to the communities they serve?

Heather: The first thing I think is important is to gain support from your leadership. It’s important they’re aware of what you’re trying to do and how it’s going to impact the hospital—not only the patient population, but their financial bottom line. Secondly, I think it’s important to have patience. Things don’t really happen overnight. We began this process with one person collecting data manually. Also, manually emailing the coding team about the patients at risk for malnutrition. But since then, we’ve been able to work with our ethics team on creating a nutrition navigator. We have standardized documentation. And the physicians automatically receive a best-practices alert. This has really be able to help improve documentation as well as improve readmission rates for the patients.

Maura: You talked a little bit about having patience through this whole process. It might be helpful to give our listeners an understanding of the length of time it took to roll out not just the pilot, but the entire program across the whole system. Do you know how long that took?

Heather: Our initial pilot study started in early 2014, and we rolled it out in 2015 to that initial site. Then, we went year by year rolling it out to each of our four acute care locations. And then, just this past year, in 2018, we rolled it out into our ambulatory setting, which is where we were working in our physician offices, counseling patients and offering the meals to those patients at risk. We’ve been working on this program for over five years now and are still trying to see how we can expand and make improvements and grow it.

Maura: Another question, because I know our listeners will be interested: Am I right that you’ve done research on malnutrition at your institution? Can you tell us a bit about some of your studies and what you found—either before you rolled out the program to help prepare for it, or anything you’ve done since then?

Heather: Once we expanded to all four acute care hospitals, we were able to get a larger sample set of data. And so we looked at data from August 2017 to September 2018. The dietitians would complete the comprehensive nutrition assessment, and they’d complete them for 29,000 patients. Out of those, about 5,500 were found to be malnourished by the nutrition-focused physical exam—that’s about 19% who had malnutrition. Of the 5500, 2,700 of those agreed to receive the meals, and said, “Yes, I’d really like to have those meals when I’m discharged home.” Unfortunately—well not unfortunately—1,700 of those once they were discharged actually started the meals. There are a lot of different reasons why people don’t actually get the meals. They may have gone to a rehab facility. Or, in our area, we have a lot of seasonal residents, so sometimes they go up north to where their other home is.
**Heather:** Out of those patients who received all four weeks of meals, we noted they only had a 20% readmission rate compared to those who only received a portion of the weeks of meals, or none at all, at 30-40%. So, you can see it’s almost half of the amount of... if they didn’t receive the meals. So, we really showed in the data again that the patients who receive meals really do have a lower incidence of readmission.

**Heather:** More recently we expanded our program to the outpatient office to reduce emergency department visits as well as admissions from home, and out of 162 patients who receive meals, we had 12 ED visits and 4 admissions within 30 days of them receiving the meals.

**Maura:** Thank you for sharing this really meaningful information. Anytime we can hear about studies and the outcomes on malnutrition, it only helps everyone. Before we sign off, do you have any other parting words?

**Heather:** I think it’s important that some of the statistics that we’ve all seen out there on the incidences of people with malnutrition—it’s just really important to try to do what you can in your institution to try to help these because what we do know is, if we’re able to identify patients with malnutrition, possibly provide meals to them, maybe look at food-insecure areas and target those in your community, we can help reduce those incidences of malnutrition, reduce incidences of hospitalization and readmission, and also reduce healthcare costs.

**Maura:** Heather, thank you so much. It’s been a pleasure speaking with you today.

**Heather:** Thank you very much.