

Geriatric Care Partners
VIP NUTRITION PROJECT -- May 2002

OBJECTIVES

- Increase the proportion of nutritionally "at risk" patients who are identified and receive appropriate nutrition evaluation, education, and follow-up
- Enhance the availability of information available to the physicians about patient's nutritional status, knowledge, diet, and resources

V.I.P. STRATEGIES

- Process Standardization
- Planned Communication

PROTOCOL

All Geriatric Care Partners staff will be made aware of signs of nutritional risk, including
***Unintentional Weight Loss *Albumin < 3.5mg.dL *BMI >26 *BMI <19 *Diabetes**

BMI Tables will be posted next to the scale in the office

All staff will be encouraged to identify patients at nutritional risk

↓
The charts of nutritionally "at risk" patients will be flagged with a pink chart sticker to facilitate their identification to all office staff.

↓
A pink Nutrition Intervention form will be readily available to facilitate evaluation and team intervention.

↓
Physicians will work with patient / family to identify nutritional problems and determine specific clinical goals.

↓
After physician visit, social worker will complete socio-economic assessment of the patient, and fax referral to appropriate team member.

↓
Patients & Families will be given printed information from the Rush Outpatient Nutrition Clinic to help facilitate their referral and be better prepared for the nutrition consultation.

↓
Team member (Nutrition or Pharmacy) will acknowledge receipt of the referral and will contact the patient.

↓
A written clinical update will be sent back to the office before the patient's next appointment.

↓
All team members will monitor progress towards specific set goals; recommend modification of goals or strategies if goals are not attained

↓
Charts will be reviewed periodically to determine # of patients who have received VIP nutrition counseling and to assess progress in attaining nutritional objectives.