

## **1. MUC16-296: Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening:**

- **In favor of MAPs preliminary recommendations:** Yes
- **General Comments on the Hospitals workgroup draft report:**

We commend the Workgroup's recommendation to conditionally support MUC16-296 for inclusion pending NQF endorsement. The prevalence of malnutrition in older adults is a growing concern because this health condition often goes undiagnosed and unrecognized, resulting in costly and sometimes fatal health outcomes. Malnutrition rates among hospitalized older adults are estimated to be as high as 39%,<sup>[1], [2]</sup> and can be caused by acute or chronic illness, injury, food insecurity or other psycho social determinants. Age, physical trauma, prolonged bed rest, and the stress of disease, surgery, or infection can all increase loss of the body's muscle and protein stores and further increase the risk for malnutrition. While many factors can impact the health and well-being of older adults, malnutrition is a condition that is linked to increased incidences of falls, hospital admissions and readmissions, chronic disease, co-morbid health conditions, psychological stress, slowed recovery and decreased independence. The estimated annual cost of disease-associated malnutrition in older adults is \$51.3 Billion.

It is essential for the healthcare team to assess malnutrition while patients are in the hospital in order to expedite healing, offer on-site nutrition interventions and education, and provide a plan for ongoing nutritional support. Inclusion of MUC16-296 will help provide value by improving quality of care and outcomes for patients.

<sup>1</sup>Kaiser MJ, Bauer JM, Räsmsch C, et al. Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment. *J Am Geriatr Soc.* 2010;58(9):1734-8.

<sup>2</sup>Pereira GF, Bulik CM, Weaver MA, Holland WC, Platts-mills TF. Malnutrition among cognitively intact, noncritically ill older adults in the emergency department. *Ann Emerg Med.* 2015;65(1):85-91.

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<sup>[1]</sup> Kaiser MJ, Bauer JM, Räsmsch C, et al. Frequency of malnutrition in older adults: a multinational perspective using the mini nutritional assessment. *J Am Geriatr Soc.* 2010;58(9):1734-8.

<sup>[2]</sup> Pereira GF, Bulik CM, Weaver MA, Holland WC, Platts-mills TF. Malnutrition among cognitively intact, noncritically ill older adults in the emergency department. *Ann Emerg Med.* 2015;65(1):85-91.

## 2. MUC16-372: Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment

- In favor of MAPs preliminary recommendations: No
- General Comments on the Hospitals workgroup draft report:

We request that the Coordinating Committee reconsider the recommendation of “refine and resubmit” for MUC16-372. After the hospital workgroup review MUC16-372 was recommended for endorsement by the Health and Well-being Standing Committee, which indicates that the measure is evidence-based, reliable, valid and feasible for use.

We commend the Workgroup’s recognition in the report that the impact of malnutrition on patients and the healthcare system is significant with conditional support of a malnutrition measure. Recent national data show that malnourished patients are five times more likely to die in the hospital, have up to 100% longer lengths of stay, and cost twice the average inpatient stay<sup>1</sup>. Thus healthcare costs related to disease-related malnutrition in the U.S. are estimated to be \$51.3 billion for those age 65 years and older<sup>2</sup>. Furthermore, 30-day readmission rates for malnourished patients in 2013 averaged 23 per 100, compared with 14.9 per 100 without malnutrition. Costs were also 26% higher for readmissions involving patients with malnutrition than average readmissions without malnutrition.<sup>3</sup>

Development and documentation of the nutrition care plan is driven by the nutrition assessment and is required to record vital patient care information, including nutrition status, diagnosis, monitoring recommendations, and interventions. Moreover, the nutrition care plan is the communication mechanism to all clinicians who interact with the patient in the hospital setting and becomes the information communicated to the next-in-line provider outside the hospital. This is particularly important as malnourished patients are more likely to be discharged to another facility<sup>4</sup> or require ongoing healthcare services after being discharged from the hospital, compared to patients who are not at risk for malnutrition.<sup>5</sup> Community-based services may include but are not limited to congregate and home-delivered meals, education and counseling, and an array of other supportive and health services. As such, documentation of the care plan in a standardized, structured, and consistent manner is a critical activity for care provision in the acute setting and to support care transitions to post-acute care or home.

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<sup>1</sup> Weiss AJ, Fingar KR, Barrett ML, Elixhauser A, Steiner CA, Guenter P, Brown MH. Characteristics of Hospital Stays Involving Malnutrition, 2013. HCUP Statistical Brief #210. September 2016. Agency for Healthcare Research and Quality, Rockville, MD.

<sup>2</sup> Snider J, et al: Economic burden of community-based disease-associated malnutrition in the United States. JPEN J Parenteral Enteral Nutr. 2014;38:55-165.

<sup>3</sup> Fingar KR, Weiss AJ, Barrett ML, Elixhauser A, Steiner CA, Guenter P & Brown MH. All-Cause Readmissions Following Hospital Stays for Patients With Malnutrition, 2013. HCUP Statistical Brief #218. December 2016. Agency for Healthcare Research and Quality, Rockville, MD.

<sup>4</sup>Chima CS, et al. Relationship of nutritional status to length of stay, hospital costs, and discharge status of patients hospitalized in the medicine service. *J Am Diet Assoc.* 1997; 97(9): 975-8.

<sup>5</sup>Zdrowski CD, et al. Malnutrition in sub-acute care. *Am J Clin Nutr.* 2002; 75: 308-313.