defeatmalnutrition.today

...vital to healthy aging

June 26, 2017

Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services, P.O. Box 8010
Baltimore, MD 21244

RE: Medicare Proposed Rule for Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Proposal to Correct the Performance Period for NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020, CMS-1679-P

Dear Ms. Verma,

The Defeat Malnutrition Today coalition appreciates the opportunity to comment on the Medicare Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program (QRP), *specifically on nutrition/malnutrition related proposals for reporting of standardized patient assessment data beginning in FY 2020 in the SNF QRP*.

Defeat Malnutrition Today is a coalition with over 60 members who are committed to defeating older adult malnutrition across the continuum of care. This is a diverse alliance of community, healthy aging, nutrition, advocacy, health care professional, faith-based, and private sector stakeholders and organizations who share the common goals of achieving the recognition of malnutrition as a key indicator and vital sign of health risk for older adults and working to achieve a greater focus on malnutrition screening, diagnosis, and intervention through regulatory and/or legislative change across the nation's health care system.

The Defeat Malnutrition Today coalition commends CMS for their recognition of the importance of identifying and treating malnutrition in the post-acute care setting. We appreciate CMS's inclusion of nutrition data elements in the standardized patient assessment for beneficiaries in PAC settings and specifically establishing malnutrition and malnutrition risk and type of nutritional approach as standardized data elements. Nutritional status and the nutrition care plan (nutritional approach) are necessary health information to achieve patient goals of care, and inclusion of these standardized elements upon admission and discharge will facilitate care coordination and safe care transitions for beneficiaries who are malnourished and at risk for malnutrition. It is important for providers and patients to understand the risks for malnutrition: what might cause it or make it worse, how to prevent it and how to connect with community nutrition support services.

We support the CMS proposal for reporting nutritional status (malnutrition or at-risk of malnutrition) and nutritional approaches as data elements (Therapeutic Diet, Mechanically Altered Diet, Parenteral IV/Feeding, Feeding Tube) for SNF admissions at the start of a Medicare Part A stay and SNF discharges at the end of the Medicare Part A stay starting in FY 2020. We recommend, however, that CMS align the definition of the "therapeutic diet" data element with the Academy of Nutrition and Dietetics definition below to help clarify the data to be reported and ensure consistent data collection across PAC settings:

"A therapeutic diet is a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral and parenteral routes as part of treatment of disease or clinical conditions to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet." (Academy of Nutrition and Dietetics: Definition of Terms, June 2017, available at: http://www.eatrightpro.org/~/media/eatrightpro%20files/practice/scope%20standards%20of%20practice/academydefinitionoftermslist.ashx).

Malnutrition is a vital sign of older adult health risk and must be addressed with great urgency

Malnutrition, a nutrition imbalance that affects both overweight and underweight patients, is unfortunately a common issue across all care settings. In the acute care hospital setting, it is estimated that approximately 20 to 50 percent of admitted patients are malnourished or at-risk of malnutrition.[1-5] According to the National Resource Center on Nutrition, Physical Activity and Aging, nearly 35-50 percent of older residents in long term care facilities are malnourished.

Chronic disease increases the risk of malnutrition in older adults. Studies estimate the prevalence of malnutrition in cancer patients is 30-87 percent,[6] in chronic kidney disease is 20-50 percent,[7] and in chronic obstructive pulmonary disease is 19-60 percent.[8] In addition, one of the fastest growing forms of elder abuse is self-neglect, which can be caused by the inability to maintain a proper (or any) diet, leading to malnutrition.

A 2017 Administration for Community Living, Center for Policy and Evaluation report on malnutrition comments "At least 1/3 of patients of all ages in developed countries, including the U.S., are malnourished when admitted to the hospital, and, if untreated, about 2/3 will have their nutritional status decline during their hospitalization." The report concludes: "Available evidence indicates that nutrition interventions in the community and hospital settings and nutrition services programs for older adults can help preserve health and well-being as well as prevent certain health services use…Hospitals, care transition, and other health care providers could conduct nutrition screenings, assessments, and interventions as their professional organizations recommend."[37]

Because malnutrition in older adults is often linked to economic and social risk factors, it can lead to more health disparities. The Congressional Black Caucus Institute in their *21st Century Council 2015 Annual Report* noted that "[t]he most benefit will occur when malnutrition care becomes a priority and routine standard of medical care." One of the steps outlined to accomplish this was "[i]ntegrating malnutrition screening and treatment into the development of evidence-based care models, such as intervention strategies to improve patient care transitions."

Malnutrition is a major concern because it can cause adverse and costly outcomes. Research documents malnourished older adults make more visits to physicians, hospitals, and emergency rooms. The nutritional status of malnourished patients can continue to worsen throughout an inpatient stay, which may lead to further increased costs. Studies show that malnutrition, as a contributing factor to post-hospital syndrome, can increase a patient's risk for a 30-day readmission, often for reasons other than the original diagnosis.[9] For example, 45% of patients who fall in the hospital have malnutrition; costs for falls overall to Medicare totaled $31 billion in 2015.[35, 36]

Malnutrition is a patient safety risk, as those who are malnourished are more likely to experience a healthcare acquired condition. Malnutrition is linked to increased rates of morbidity, increased incidence of healthcare acquired pressure ulcers and infections, falls, delayed wound healing, decreased

respiratory and cardiac function, poorer outcomes for chronic lung diseases, increased risk of cardiovascular and gastrointestinal disorders, reduced physical function, development of nosocomial infections, and impairment of non-specific and cell-mediated immunity.[10]

While malnutrition is a prevalent and potentially costly problem, it is also preventable. Effective and timely screening is essential to help providers make accurate diagnoses, and early nutrition interventions have been shown to substantially reduce readmission rates,[11-13] as well as complication rates, pressure ulcer incidence, length of stay, cost of care, and in some cases, mortality.[10]

Malnutrition care (from screening, assessment, and diagnosis to care plans and interventions) is a low-risk and low-cost solution to help improve the quality of clinical care.

Malnutrition is a cross-cutting, clinically relevant issue

In future rule-making, we recommend that CMS consider expanding their proposals to fill gaps across acute, post-acute care and community settings.

The "National Blueprint: Achieving Quality Malnutrition Care for Older Adults" (The Blueprint) calls for a range of strategies to prevent and reduce malnutrition among older adults, including "improve access to high-quality malnutrition care and nutrition services by adopting clinically relevant malnutrition quality measures in public and private accountability programs across the care continuum."

The Blueprint also highlights many other recommendations and actionable ways that public and private sectors can work together to fill the gaps in quality malnutrition care for older adults. The Blueprint was developed with input from the Malnutrition Quality Collaborative, which included non-profit organizations, state governments, professional organizations, and healthcare associations, among others. ***We would welcome the opportunity to review the National Blueprint with CMS and identify ways we can collaborate to prevent and reduce malnutrition among older adults across the care continuum.***

Conclusions

With systematic screening, assessment, diagnosis and intervention, malnutrition can be identified and addressed to effectively reduce mortality rates, readmission rates, and complication rates such as increased length of stay and cost of care. The estimated annual cost of disease-associated malnutrition in older Americans is more than $50 billion.[34] Quality malnutrition care has been shown to create savings and improve patient care. In addition to the clinical benefits, implementing quality malnutrition care is a low-cost, easy intervention.

In short, we appreciate the opportunity to comment on this proposed rule and we support the CMS proposals to report malnutrition and malnutrition-risk and nutritional approach data elements (Therapeutic Diet, Mechanically Altered Diet, Parenteral IV/Feeding, Feeding Tube) for SNF admissions at the start of the Medicare Part A Stay admission and SNF discharges at the end of the Part A Stay. We recommend CMS align the definition of the "therapeutic diet" data element with the Academy of Nutrition and Dietetics definition as referenced above.

Sincerely,
Defeat Malnutrition Today

References

1. Barker LA, Gout BS, Crowe TC. Hospital malnutrition: Prevalence, identification and impact on patients and the healthcare system. *Int J Environ Res Public Health*. 2011; 8(2):514-527
2. Bistrian BR, Blackburn GL, Hallowell E, Heddle R. Protein status of general surgical patients. *JAMA*. 1974;230(6):858-860
3. Christensen KS, Gstundtner KM. Hospital-wide screening improves basis for nutrition intervention. *J Am Diet Assoc.*1985;85(6):704-706
4. Lim SL, Ong KC, Chan YH, et al. Malnutrition and its impact on cost of hospitalization, length of stay, readmission and 3-year mortality. *Clin Nutr.* 2012;31(3)345-350
5. Somanchi M, Tao X, Mullin GE. The facilitated early enteral and dietary management effectiveness trial in hospitalized patients with malnutrition. *JPEN J Parenter Enteral Nutr.* 2011;35(2):209-216
6. Kumar NB. *Nutritional Management of Cancer Treatment Effects*.2012.
7. Pupim, L.B. et al. Nutrition and Metabolism in Kidney Disease. *Seminars in Nephrology* 2006;26,134-157.
8. Hunter AM, et al. The nutritional status of patients with chronic obstructive pulmonary disease. *Am Rev Respir Dis*. 1981;124(4):376–381.
9. Krumholz HM. Post-hospital syndrome – An acquired, transient condition of generalized risk. *N Engl J Med.* 2013; 368(2):100-102
10. Tappenden KA et al. Critical role of nutrition in improving quality of care: an interdisciplinary call to action to address adult hospital malnutrition. *JPEN J Parenter Enteral Nutr*. 2013 Jul;37(4):482-97
11. Brugler L, DiPrinzio MJ, Bernstein L. The five-year evolution of a malnutrition treatment program in a community hospital. *Jt Comm J Qual Improv.* 1999;25(4):191-206
12. Gariballa S, Forster S, Walters S, Powers H. A randomized, double blind, placebo-controlled trial of nutritional supplementation during acute illness. *Am J Med.* 2006;119(8):693-699
13. Philipson TJ, Snider JT, Lakdawalla DN, Stryckman B, Goldman DP. Impact of oral nutritional supplementation on hospital outcomes. *Am J Manag Care*. 2013;19(2):121-128
14. Gariballa S, et al. A randomized, double-blind, placebo-controlled trial of nutritional supplementation during acute illness. *Am J Med* 2006;119(8):693-699.
15. Stratton RJ et al. Enteral nutritional support in prevention and treatment of pressure ulcers: a systematic review and meta-analysis. *Ageing Res Rev*. 2005;4(3):422-450.
16. Milne AC, et al. Protein and energy supplementation in elderly people at risk from malnutrition. *Cochrane Database Syst Rev*. 2009 Apr 15(2):CD003288.
17. Brugler L, et al. The five-year evolution of a malnutrition treatment program in a community hospital. *Jt Comm J Qual Improv*, 1999 Apr; 25(4):191-206
18. Smith PE, et al. High-quality nutritional interventions reduce costs. *Healthcare Financial Management* 1997;51:66-69.
19. Austrums E, et al. Postoperative enteral stimulation by gut feeding improves outcomes in severe acute pancreatitis. *Nutrition* 2003; 19:487-491.
20. Akner G, et al. Treatment of protein-energy malnutrition in chronic nonmalignant disorders. *Am J Clin Nutr* 2001;74:6.
21. Potter J, et al. Routine protein energy supplementation in adults: systematic review. *Br Med J* 1998;317;495-501.
22. Potter JM, et al. Protein energy supplements in unwell elderly patients – a randomized controlled trial. *JPEN J Parenter Enteral Nutr* 2001;25:323-329.
23. Delmi M, et al. Dietary supplementation in elderly patients with fractured neck of the femur. *Lancet* 1990;335:1013-1016.
24. Lacson E, et al. Outcomes associated with intradialytic oral nutritional supplements in patients undergoing maintenance hemodialysis: a quality improvement report. *Am J Kidney Dis*. 2012.
25. Stratton RJ, et al. Are oral nutritional supplements of benefit to patients in the community? Findings from a systematic review. *Curr Opin Clin Nutr Metab Care* 2000;3:311-315.
26. Davidson W, et al. Weight stabilization is associated with improved survival duration and quality of life in unresectable pancreatic cancer. *J Clin Nutr* 2004;22:239-247.
27. Moses AW, et al. Reduced total energy expenditure and physical activity in cachetic patients with pancreatic cancer can be modulated by an energy and protein dense oral supplement enriched with n-3 fatty acids. *Br J Cancer* 2004;90:996-1002.
28. Moses A, et al. An experimental nutrition supplement enriched with n-3 fatty acids and antioxidants is associated with an increased physical activity level in patients with pancreatic cancer cachexia. *Clin Nutr* 2001;20(suppl3):S21.
29. Payette H, et al. Benefits of Nutritional Supplementation in Free-living, Frail, Undernourished Elderly People. *J Am Diet Assoc* 2002;102:1088-1095.
30. Isenring EA, et al. Nutrition intervention is beneficial in oncology outpatients receiving radiotherapy to the gastrointestinal or head and neck area. *Br J Cancer* 2004;91:447-452.

31. Mueller C, Compher C, Ellen DM, American Society for P, Enteral Nutrition Board of D. A.S.P.E.N. clinical guidelines: Nutrition screening, assessment, and intervention in adults. *JPEN J Parenter Enteral Nutr*. 2011;35(1):16-24.
32. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates, 81 FR 56761 (22 August 2016), pp. 1985.
33. Deutz NE, Matheson EM, Matarese LE, et al. Readmission and mortality in malnourished, older, hospitalized adults treated with a specialized oral nutritional supplement: A randomized clinical trial. *Clinical nutrition* (Edinburgh, Scotland). 2016;35(1):18-26.
34. 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.
35. Bauer JD, et al. Nutritional status of patients who have fallen in an acute care setting. *J Hum Nutr Diet.* 2007;20:558-564.
36. Burns EB, Stevens JA, Lee RL. The direct costs of fatal and non-fatal falls among older adults—United States. *J Safety Res* 2016:58.
37. Tilly J. Opportunities to improve nutrition for older adults and reduce risk of poor health outcomes. Administration for Community Living. http://nutritionandaging.org/wp-content/uploads/2017/03/Malnutrition-Issue-Brief-final-3-2017.pdf. 2017.