May 5, 2017

RE: QIO Program Priorities for 12th Scope of Work

The Defeat Malnutrition Today coalition appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS)'s Quality Improvement Organizations' (QIO)'s Program Priorities for its 12th Scope of Work.

Defeat Malnutrition Today is a coalition with over 55 member organizations who are committed to defeating older adult malnutrition. 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 goals of achieving the recognition of malnutrition as a key indicator and vital sign of older adult health and working to achieve a greater focus on malnutrition screening and intervention through regulatory and/or legislative change across the nation's health care system. The coalition includes the QIO partner the AARP Foundation.

We support the overall goals of the CMS Quality Strategy and are pleased to learn of the successes the QIO's 11th Scope of Work has had in implementing these goals.

In response to CMS's call for comments on the 12th Scope of Work, we are recommending that CMS include a focus on older adult malnutrition, specifically at the community level and during care transitions in the QIN-QIO's work.

Background on the Malnutrition Problem

Malnutrition, a nutrition imbalance that affects both overweight and underweight patients, is unfortunately a common issue in the acute care hospital setting, affecting approximately 20 to 50 percent of admitted patients.[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 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."

Because malnutrition in older adults is often linked to economic and social 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." The Congressional Black Caucus Institute took this a step further in their 2017 *Transition Report*, recommending policymakers "Recognize malnutrition as a preventable occurrence in acute care hospitals and support appropriate screening and treatment efforts, including the adoption of malnutrition-related quality measures in federal quality reporting programs."

Malnutrition is a major concern because it can cause adverse outcomes. Research documents malnourished older adults make more visits to physicians, hospitals, and emergency rooms. Malnourished patients can continue to worsen throughout an inpatient stay, which may lead to 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]

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, 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. Prompt nutrition intervention can significantly improve patient outcomes, with:

- 28 percent decrease in avoidable readmissions,[14]
- 25 percent reduction in pressure ulcer incidence,[15]
- 4 percent fewer overall complications,[16]
- Reduced average length of stay of approximately two days,[17-18]
- Decreased mortality,[19-24] and
- Improved quality of life.[25-30]

Recommendations

1. **Include malnutrition as an emerging health issue to be addressed by QIOs**

We recommend that older adult malnutrition overall be considered by QIOs as an "emerging health issue" as the 12th Scope of Work is written. For the reasons stated and cited, malnutrition is burdensome and costly, and it needs to be addressed as a quality issue generally throughout the programs.

2. **Focus on malnutrition as a part of care transitions and community care**

QIN-QIOs already work with Area Agencies on Aging (AAAs) to provide care transitions assistance for older adults with chronic conditions. These same older adults are more likely to be malnourished and in need of nutrition assistance; AAAs are well-equipped to handle this issue since they usually either run or work closely with those who run community nutrition programs, which help alleviate malnutrition in the community and in those patients who are transitioning home to the community. They can provide direct referrals of patients to those programs—including Older Americans Act programs, USDA programs, and other federal, state and locally-run nutrition options. Encouraging this focus simply makes sense.

We appreciate your consideration of our recommendations. For further recommendations on community malnutrition care, you may wish to read our new *National Blueprint: Achieving Quality Malnutrition Care for Older Adults,* which can be found at www.defeatmalnutrition.today/blueprint. You can also review resources available in the new Community Malnutrition Resource Hub (https://www.ncoa.org/center-for-healthy-aging/resourcehub/) recently promoted by the Administration on Aging.

Please feel free to contact us at info@defeatmalnutrition.today if you have any questions or if you need additional information.

Sincerely,

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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):100-102Tappenden 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
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. http://acl.gov/About_ACL/Budget/docs/FY_2016_ACL_CJ.pdf
32. Snider JT et al. Effect of hospital use of oral nutritional supplementation on length of stay, hospital cost, and 30-day readmissions among Medicare patients with COPD. *Chest.* 2015;147(6):1477-1484.