January 4, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244

Re: CMS 3317-P, Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Proposed Rule, November 3, 2015.

Dear Mr. Slavitt,

The DefeatMalnutrition.Today coalition appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to revise discharge planning requirements that Hospitals--including Long-Term Care Hospitals and Inpatient Rehabilitation Facilities, and Critical Access Hospitals--and Home Health Agencies must meet in order to participate in the Medicare and Medicaid programs (80 Fed. Reg. 68126).

In response to these proposals, we recommend that the following discharge planning requirements be included to improve clinical outcomes of malnourished and nutritionally at-risk Medicare and Medicaid beneficiaries:

1. Include nutritional status in the proposed new "standard design" as providers evaluate a patient's discharge needs and as necessary medical information for a receiving facility
2. Include registered dietitian nutritionists (RDNs) on core care transitions teams to develop a discharge plan that addresses diet and therapeutic nutrition requirements for patients identified as at-risk or malnourished prior to discharge
3. Encourage hospitals and other care facilities to partner with Older Americans Act nutrition providers to ensure better care transitions after discharge
4. Implement malnutrition-related quality measures in future Hospital and Post-Acute Care Quality Reporting and Value-Based Purchasing programs.

In addition, we recommend CMS update its discharge-related materials, such as the "Your Discharge Planning Checklist" (http://www.medicare.gov/Pubs/pdf/11376.pdf) tool, to include information helpful in screening and intervening for malnutrition and thus encourage patients to specifically ask about their own role in addressing nutritional status in their discharge care plans.

The DefeatMalnutrition.Today coalition was recently formed to address the challenges of malnutrition in older adults. Our goals are: 1) to achieve the recognition of malnutrition as a key indicator and vital sign of older adult health and 2) to achieve a greater focus on older adult

malnutrition screening and intervention through regulatory and/or legislative change across the nation's health care system. We have 30 national, state, and local member organizations.

Our detailed comments follow.

Background on The Malnutrition Problem

Malnutrition, a nutrition imbalance that affects both overweight and underweight patients, is a common issue in the acute care hospital setting, affecting approximately 20 to 60 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.

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."

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 through an inpatient stay, which may lead to increased costs. Generally, care transition programs are limited in their inclusion of nutrition-specific recommendations and practices. 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.

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,[10-12] as well as complication rates, length of stay, cost of care, and in some cases, mortality.[13]

Malnutrition intervention is a low-risk and low-cost solution to help improve the quality of clinical care and care transitions. 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]

Current efforts to address malnutrition quality care are being led by the Academy of Nutrition and Dietetics and Avalere Health along with the support of other stakeholders. In 2015, a national Malnutrition Quality Improvement Initiative (MQII) was launched with an initial focus on hospitalized older adults. The objective of the MQII is to advance optimal, patient-driven malnutrition care from admission thru discharge by:

- creating de novo electronic clinical quality measures that matter to patients and providers
- improving malnutrition care with an interdisciplinary care team toolkit and
- advancing tools that can be integrated into EHR systems.[31]

Results from the initiative and feedback from additional sites participating in a national Learning Collaborative will be available in 2016.

Specific Recommendations for Malnutrition-Related Discharge Planning Requirements

1. Include nutritional status in the proposed new "standard design" as providers evaluate a patient's discharge needs and as necessary medical information for a receiving facility

The DefeatMalnutrition.Today coalition urges CMS to require nutritional status and a nutrition care plan as necessary medical information for patients' caregivers and outpatient medical providers during "discharge to home," as well as for a receiving facility.

Diet and nutrition planning are often mentioned in the context of medication management and compliance with cultural and religious practices, rather than for avoiding malnourishment. While emphasizing healthy diet is important in the context of medication management, it is equally important for hospitals, post-acute care 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 applaud CMS for advancing nutrition as a key indicator of adult health by including protein calorie malnutrition in the CARE Assessment Tool as an example of other diagnoses, comorbidities, and complications that should be captured and communicated across care settings.[32] However, unless ***required***, the information transfer to other practitioners is often variable.

We recommend that care transition programs should consistently communicate nutritional status and nutrition care plans for the receiving facility and healthcare practitioners, as well as provide

nutrition-specific context in discharge materials for the patient and family caregivers to achieve patient goals of care.

Patients and family caregivers want and need this information. A recent survey by the Gerontological Society of America's National Academy on an Aging Society found that Americans understand identifying and treating malnutrition is important for older adult health and would like more information about the problem. Further, the survey identified that family caregivers wished older adults in their care were using more community nutrition resources such as home meal delivery programs.[33]

Use of specific tools and protocols for nutrition intervention (such as checklists and lists of community resources) will help ensure that all patients and family caregivers get the necessary support and services to address malnutrition. Many providers may have some nutrition-specific education or discharge planning tools; however, information is inconsistent across facilities, caregivers, and patients. Indeed, one of the six core recommendations of the interdisciplinary Alliance for Patient Nutrition outlined in their consensus paper is to "Develop a Comprehensive Discharge Nutrition Care and Education Plan." The Alliance recommends that "[h]ospitals must develop clear, standardized written instructions for nutrition care at home, including rationale for and details on diet instruction and any recommendations on ONS [oral nutrition supplements], vitamin and/or mineral supplements that can be given to the patient and his or her caregiver upon hospital discharge."[13]

Communication of a patient's nutritional status and recommended care plan with primary care physicians and other providers post-discharge is critical to ensure patient safety and continuity of care and to promote healing and recovery.

2. **Include registered dietitian nutritionists (RDNs) on core care transitions teams with nurses and social workers to develop discharge plans that includes nutrition education, diet and therapeutic nutrition requirements for patients identified as malnourished or at risk of malnutrition**

We support CMS's proposal that the practitioner responsible for the care of the patient be involved in the ongoing process of establishing the patient's goals of care and treatment preferences that inform the discharge plan. We recommend that if a patient is assessed as malnourished or at risk of malnutrition by an RDN during the hospital stay that the RDN, in accordance with the hospital's discharge planning policy, will coordinate with the nurse and social worker to develop a discharge plan that includes nutrition education, diet and therapeutic nutrition recommendations.

3. **Encourage hospitals and other care facilities to partner with Older Americans Act nutrition providers to ensure better care transitions after discharge**

We applaud CMS's proposal that hospitals consider community-based care for discharged patients. We would particularly highlight the importance of Older Americans Act (OAA) nutrition programs (mentioned as a "non-health care service") to discharged patients. These programs are essential to allowing older adults to live safely and independently in their

communities. We recommend that hospitals partner with these home- and community-based nutrition services to ensure that patients who may not be able to prepare meals for themselves receive a proper diet. This will reduce the risk of malnutrition for these older adults, in turn reducing hospital readmissions. It will also significantly lower the chances that they will need residential care. Seventy-seven percent of congregate and 84 percent of home-delivered meal participants say they eat healthier meals because of OAA nutrition programs, and 61 percent of congregate and 93 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes. Further, the Administration for Community Living states that the lowest prevalence of malnutrition is found among older adults in the community.[34] By providing access to meals programs, older adults can remain in the community and also stay nourished.

4. Implement malnutrition-related quality measures in future Hospital and Post-Acute Care Quality Reporting and Value-Based Purchasing programs

Malnutrition is not only a patient safety risk for hospitalized patients, it can negatively impact patient outcomes in any healthcare setting. Early identification of Medicare and Medicaid beneficiaries at risk for malnutrition, prompt nutrition intervention, and implementation of an effective care transition plan for patients diagnosed as malnourished or at risk for malnutrition are critical to improve outcomes and patient safety by reducing complications which can lead to readmissions including infections, falls, pressure ulcers. Despite guidelines and standards, there are variations in care that can negatively impact time to nutrition intervention and care coordination upon discharge to home or other post-acute care settings.

Addressing malnutrition aligns with the CMS National Quality Strategy Goal of identifying cross-cutting measures that are important to patients and providers. As such, there is an opportunity to address this measure gap and to align incentives for providers by standardizing a malnutrition-related measure(s) across acute and post-acute care quality programs.

As malnutrition is an independent risk factor for poor outcomes and increased costs across healthcare settings, the DefeatMalnutrition.Today coalition urges CMS to adopt malnutrition-related quality measure(s) in the Hospital Inpatient Quality Reporting (IQR), Hospital Value Based Purchasing (VBP), and Post-Acute Care Quality Programs as soon as feasible, to address potential patient-safety risks and to improve patient outcomes. In the PAC quality programs we recommend that CMS implement a "nutritional status domain" highlighting nutritional status as a key indicator of adult health. Implementing malnutrition care quality measures would address a gap where there is variation in clinical practice *and* where there is an opportunity to improve.

Specific Recommendations for CMS Discharge-Related Materials

Update CMS discharge-related materials, such as the "Your Discharge Planning Checklist" (http://www.medicare.gov/Pubs/pdf/11376.pdf) tool, to include information helpful in screening and intervening for malnutrition and thus encourage patients to specifically ask about their own role in addressing nutritional status in their discharge care plans

We commend CMS on the development of tools for patients and their caregivers preparing to leave a hospital, nursing home, or other care setting. We believe the "Your Discharge Planning

Checklist" is an important tool to help patients engage in post-discharge care planning and to assist with their recovery, including improving their nutritional status if they were diagnosed at-risk or malnourished during their hospital stay.

Updating this Checklist could help patients understand the critical role of nutrition in their recovery and encourage patients to specifically ask about their role in addressing nutritional status in their care plan. We recommend CMS consider the following updates to include nutrition:

- Instructions
  - Include *registered dietitian nutritionist* when providing examples of staff to talk to about the items in the Checklist.
- "Your Health" Action Items
  - Ask the staff about your health condition *and nutritional status* and what you can do to help yourself get better.
  - Include a check box for *"Ask about any special diet instructions".*
  - When referencing drugs, vitamins, herbal supplements *include oral nutrition supplements.*
- Recovery & Support
  - Ask if you will need medical equipment (like a walker *or weight scale*).
  - Ask for a summary of your health *and nutritional status.*
- My Drug List
  - When referencing drugs, vitamins, herbal supplements *include oral nutrition supplements*.
- Resources
  - *Add Meals on Wheels Locator:* The Meals on Wheels Association of America represents those who provide meal services to homebound people in need.

We appreciate your consideration of our comments. Please feel free to contact us at info@defeatmalnutrition.today if you have any questions or if you need additional information.

Sincerely,

DefeatMalnutrition.Today

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