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October 7, 2016

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

RE: Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees: Measures for Dual Enrollees

Dear Mr. Slavitt:

The DefeatMalnutrition.Today coalition appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees related to measures for dual enrollees.

DefeatMalnutrition.Today is a coalition with over 45 members 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.

QUALITY MEASURE DEVELOPMENT FOR DUAL ENROLLEES

We applaud CMS' recognition that quality measure development and maintenance is a key component to ensuring healthy patient outcomes, especially for those individuals of particularly vulnerable populations, the dual enrollees. We encourage CMS to include malnutrition-related quality measures as key components to ensuring long-term health outcomes for dual enrollees. Additional comments supporting the proposals follow below.

Recommendations to Advance Better Care for Older Adults

Early identification of dual enrollee beneficiaries at risk for malnutrition, prompt nutrition intervention and implementation of an effective care transition plan for patients diagnosed as malnourished or at risk of malnutrition is critical to help reduce morbidity, mortality, and costs and thus, improve quality outcomes. As CMS seeks to improve the health of the U.S. population

by supporting proven interventions to deliver higher-quality care,[1] we recommend that CMS advance other policies to ensure high-quality, timely and coordinated malnutrition care:

- Address malnutrition measure gaps in future quality and incentive alignment programs across healthcare settings.
- Include nutritional status and a nutrition care plan in the transfer of health information for patients, caregivers and medical providers.
- Include malnutrition screening, assessment, diagnosis, treatment, and care coordination as quality metrics in the Hospitalization for Ambulatory Care Sensitive Conditions to reduce the negative impact on health outcomes for those who are hospitalized for these kinds of issues.
- Identify malnutrition as one of the Ambulatory Care Sensitive Conditions, to ensure consistent care and care coordination.

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. In earlier rule-making, CMS recognized a number of studies have "shown the prevalence of malnutrition among hospital patients, estimating that anywhere between 20 and 50 percent of hospital inpatients are either malnourished or at risk for malnutrition, depending on the particular patient population and the criteria used to assess these patients."[2] 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 20-87 percent,[3] in chronic kidney disease is 20-50 percent,[4] and in chronic obstructive pulmonary disease is 19-60 percent.[5] 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. According to a report from the Agency for Healthcare Research and Quality, older African Americans have a significantly higher risk of malnutrition (defined as unintentional weight loss) when compared to Caucasians.[6] 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

[1] CMS Quality Strategy

[2] 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

[3] Kumar NB. Nutritional Management of Cancer Treatment Effects.2012.

[4] Pupim, L.B. et al. Nutrition and Metabolism in Kidney Disease. Seminars in Nephrology 2006;26,134-157.

[5] Hunter AM, et al. The nutritional status of patients with chronic obstructive pulmonary disease. Am Rev Respir Dis. 1981;124(4):376–381.

[6] Kane RL et al. Common syndromes in older adults related to primary and secondary prevention. Evidence Synthesis/Technology Assessment Number 87. AHRQ Publication NO. 11-05157-EF-1, July 2011.

development of evidence-based care models, such as intervention strategies to improve patient care transitions."

Malnutrition is a patient safety risk, as those who are malnourished are more likely to experience a healthcare acquired condition. An indication of the growing awareness of the importance of malnutrition as a safety issue is that malnutrition is one of the five patient safety risk areas represented in the 2015 Leapfrog Group Hospital Survey. Malnutrition is linked to increased rates of morbidity, increased incidence of healthcare acquired pressure ulcers and infections, falls, delayed wound healing, and decreased respiratory and cardiac function, poorer outcomes for chronic lung diseases, increased risk of cardiovascular and gastrointestinal disorders, reduced physical function, and development of nosocomial infections. In an epidemiologic analysis of 887,189 major surgery cases drawn from the Healthcare Cost and Utilization Project (HCUP) Nationwide Inpatient Sample (NIS), malnutrition was associated with an increased risk of severe events. Patients with malnutrition were four times more likely to develop pressure ulcers, two times more likely to develop surgical site infections, 16 times more likely to develop intravascular device infections, and five times more likely to develop catheter-associated urinary tract infections.[7] Because of the link between malnutrition and healthcare-acquired infections, there has been a recent call for healthcare policy change to address the issue.[8]

Identifying patients who are malnourished or at-risk of malnutrition is vital because, in addition to poor clinical and health outcomes, it can increase healthcare resource utilization and costs. Research documents malnourished older adults make more visits to physicians, hospitals and emergency rooms. Malnourished or at-risk patients can continue to worsen through an inpatient stay, which may also 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 care is an important part of patient-centered care. According to a recent survey by the National Academy on an Aging Society, "Americans are aware that malnutrition can impact older adult health and independence, and they want to learn more about how to identify and treat this problem." Further, a report on the survey quotes Vice Admiral Vivek Murthy, MD, MBA, U.S. Surgeon General's statement at the 2015 White House Conference on Aging, where he explained "The way to build the foundation for a stronger America is to create a culture of prevention that has three pillars to it—strong and healthy nutrition…physical activity, and…emotional and mental well-being. We have to build and support and sustain those pillars if we want to create a culture of prevention."[10]

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[7] Dougherty D, et al. Nutrition care given new importance in JCAHO standards. Nutr Clin Pract. 1995; 10(1): 26-31

[8] Godamunne K, et al. Malnutrition and healthcare-acquired infections: the need for policy change in an evolving healthcare landscape. J Hosp Infect. 2016;93(1);9-11.

[9] Krumholz HM. Post-hospital syndrome – An acquired, transient condition of generalized risk. N Engl J Med. 2013; 368(2):100-102

[10] National Academy for an Aging Society, The Gerontological Society of America: What we know and can do about malnutrition. Profiles of an Aging Society. 2015.

Malnutrition is Preventable

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,[11,12,13] as well as complication rates, length of stay, cost of care, and in some cases, mortality.[14]

Nutrition intervention is a low-risk, low-cost clinical strategy to help improve the quality of hospital care and care transitions. Prompt nutrition intervention can significantly improve patient outcomes, with:

- 28% decrease in avoidable readmissions,[15]
- 25% reduction in pressure ulcer incidence,[16]
- 14% fewer overall complications,[17]
- Reduced average length of stay of approximately 2 days,[18,19]
- Decreased mortality [20,21,22,23,24,25] and
- Improved quality of life. [26,27,28,29,30,31]

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[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] 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

[15] 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.

[16] Stratton RJ et al. Enteral nutritional support in prevention and treatment of pressure ulcers: a systematic review and metaanalysis. Ageing Res Rev. 2005;4(3):422-450.

[17] Milne AC, et al. Protein and energy supplementation in elderly people at risk from malnutrition. Cochrane Database Syst Rev. 2009 Apr 15(2):CD003288.

[18] 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

[19] Smith PE, et al. High-quality nutritional interventions reduce costs. Healthcare Financial Management 1997;51:66-69.

[20] Austrums E, et al. Postoperative enteral stimulation by gut feeding improves outcomes in severe acute pancreatitis. Nutrition 2003; 19:487-491.

[21] Akner G, et al. Treatment of protein-energy malnutrition in chronic nonmalignant disorders. Am J Clin Nutr 2001;74:6.

[22] Potter J, et al. Routine protein energy supplementation in adults: systematic review. Br Med J 1998;317;495-501.

[23] Potter JM, et al. Protein energy supplements in unwell elderly patients – a randomized controlled trial. JPEN J Parenter Enteral Nutr 2001;25:323-329.

[24] Delmi M, et al. Dietary supplementation in elderly patients with fractured neck of the femur. Lancet 1990;335:1013-1016.

[25] 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.

[26] 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.

Recommendation for Malnutrition Quality Measures

Early identification of Medicare beneficiaries at risk for malnutrition, prompt diagnosis, nutrition intervention, and implementation of an effective care transition plan for patients diagnosed as malnourished or at risk of malnutrition are critical to help reduce morbidity, mortality, and costs. While older adults may be at-risk or become malnourished in any setting, the trigger of a hospitalization can exacerbate and accelerate malnutrition and the risk of malnutrition. Inclusion of malnutrition as a quality measure for dual beneficiaries provides an opportunity for immediate intervention with timely (1) screening, assessment, diagnosis and nutrition intervention; (2) execution of nutrition care plan upon admission through discharge; and (3) care coordination to home or other post-acute care sites.[32]

Malnutrition as a Quality Measure

DefeatMalnutrition.Today recommends that CMS adopt a malnutrition-related quality measure set for all dual enrollees. This will allow for improved health outcomes of these individuals as early identification of those at risk for malnutrition, prompt nutrition intervention and implementation of an effective care transition plan for patients diagnosed as malnourished or at risk of malnutrition are critical to improve outcomes and patient safety by reducing complications such as infections, falls, and pressure ulcers. Inclusion of malnutrition quality measures could also reduce some of the co-morbidities that many of the dual beneficiaries suffer from and improve limitations upon activities of daily living

The Academy of Nutrition and Dietetics recently submitted a set of malnutrition care electronic Clinical Quality Measures to the National Quality Forum for endorsement. The four malnutrition care quality measures were provided to CMS for review and acceptance into the Federal Quality Program - Hospital Inpatient Quality Reporting Program. The specific quality measures are:

- NQF #3087: Completion of a Malnutrition Screening within 24 hours of Admission
- NQF #3088: Completion of a Nutrition Assessment for Patients Identified as At-Risk for Malnutrition within 24 hours of a Malnutrition Screening

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[27] 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.

[28] 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.

[29] 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.

[30] Payette H, et al. Benefits of Nutritional Supplementation in Free-living, Frail, Undernourished Elderly People. J Am Diet Assoc 2002;102:1088-1095.

[31] 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.

[32] Tappenden K, 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.

- NQF #3089: Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment
- NQF #3090: Appropriate Documentation of a Malnutrition Diagnosis

Moreover, for those dual beneficiaries who may be hospitalized for Ambulatory Care-Sensitive Conditions (ACSC), malnutrition should be characterized as a measurement for those conditions. Identifying malnutrition as a component of ACSC will help ensure that being malnourished will not continue to place such a large burden on the health care system. Early identification will help provide treatment in the community settings, thereby reducing the burden on hospitals and improving health outcomes for dual beneficiaries.

Malnutrition Screening, Assessment, Diagnosis, and Treatment as Quality Metrics

Moreover, including malnutrition screening, assessment, diagnosis, and nutrition interventions as key quality metrics for organizations to meet will help reduce the likelihood of a negative impact on quality of life for dual enrollees and there should be a corresponding reduction in hospital admissions for these quality measures.

Correspondingly, care transition and care coordination plans should contain requirements for nutrition interventions, malnutrition screenings, assessments and diagnoses for all dual enrollees. These types of plans are a natural by-product of implementing a quality measure associated with dual beneficiaries having the opportunity to live in home or community based settings for as long as possible. Screening, assessment, diagnosis and implementation of nutrition care plans will help improve this quality outcome by reducing one trigger factor for an individuals' transition from community-based care to long-term service and supports.

This would also improve the likelihood of individuals staying in their homes for longer, especially given the inclusion of home health aides and the provision of care at home as a key quality metric for these new rules. Including malnutrition screening, assessment, diagnosis and treatment as a component to home health care with personal aide assistance could reduce malnutrition rates and thereby decrease the impact malnutrition has on older adults; e.g. improved health outcomes, reduced falls, and reduced hospital admission rates. Access to personal aide assistance could help individuals remain in the community longer, improve population health and quality of life, and lower the risk of adverse events. Personal aide assistance assessment should include malnutrition screening to include that provision of care for the dual beneficiaries as needed/assessed.

Incorporate Multi-Disciplinary Quality Improvement Toolkits

To support quality improvement and implementation of optimal malnutrition care, the Malnutrition Quality Improvement Initiative (MQII) has developed a multi-disciplinary toolkit that is available now.[33] In addition, a new Malnutrition Quality Collaborative is starting the process of creating a *Blueprint* to provide functional solutions facing the acute, post-acute, and community care settings for older adults suffering from malnutrition, to help guide continued

[33] http://mqii.today

conversations regarding the importance of malnutrition as a quality measurement of health. These tools should be adopted by care providers and used by CMS to provide a basis for the inclusion of a malnutrition quality measure set for dual beneficiaries. DefeatMalnutrition.Today appreciates CMS' consideration to adopt malnutrition as a quality measure set as soon as feasible for all dual enrollees seeking treatment for malnutrition.

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 any additional information.

Sincerely,

DefeatMalnutrition.Today