Advancing Patient-Centered Malnutrition Care Transitions

Mujahed Khan, MBA, RDN, LDN, Academy of Nutrition and Dietetics
Sharon McCauley, MS, MBA, RDN, LDN, FADA, FAND, Academy of Nutrition and Dietetics
Kelsey Jones Pratt, MPA, Avalere Health
Meredith Ponder Whitmire, JD, Defeat Malnutrition Today
Robert Blancato, MPA, Defeat Malnutrition Today

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WHAT WE LEARNED

Significant opportunities exist to facilitate improved care for patients with poor nutrition or malnutrition as they transition across care settings; operationalizing multi-stakeholder recommendations to enhance screening and nutrition care, data infrastructure, and patient education and shared decision making can address these needs and improve patients' overall health.

BACKGROUND

Malnutrition--both under and overnutrition--is an important issue that can impact functionality, healthy aging, and quality of life. Malnutrition affects individuals in acute, post-acute, and community settings alike, and includes overweight and obese individuals who lack sufficient nutrition (Figure 1).

Figure 1. Nutrition and the US Population

Care coordination and smooth transitions across the care continuum are critical for patients with poor nutrition or malnutrition, especially older adults. To date, care standards and associated tools to address nutrition status have not been consistently adopted into care coordination models (e.g., the patient-centered medical home, accountable care) or population health management solutions (e.g., comprehensive shared care plans, the transitional care model, or risk stratification models) or across care settings, particularly as patients transition care.

OBJECTIVES

1. To understand barriers to better integration of malnutrition care into system-level care pathways
2. To identify opportunities for screening and nutrition care, patient education and shared decision making, and data infrastructure to facilitate improved transitions for patients with poor nutrition or malnutrition between care settings.

METHODS

Avalere Health, the Academy of Nutrition and Dietetics ("the Academy"), and the Defeat Malnutrition Today coalition convened a national Dialogue event, "Advancing Patient-Centered Malnutrition Care Transitions" on March 14, 2018 in Washington, D.C. The event sought to bring together multi-stakeholder representatives of organizations engaged in the delivery of care or support for malnourished and at risk individuals, including clinicians, (e.g., physicians, dietitians), social workers, payers, professional societies, patient and caregiver advocacy groups, and community-based service providers, to address malnutrition-focused transitional care gaps. The objectives of the day-long Dialogue were to:

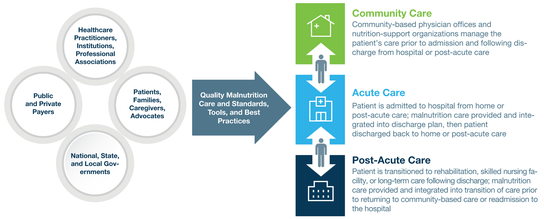
1. Evaluate the current state of care transitions for malnourished patients and patients at risk for malnutrition;
2. Identify high-priority care transition gaps and opportunities to address these gaps across the care continuum; and
3. Outline key considerations for integrating malnutrition care into system-level care pathways to support patient goals and improve outcomes.

In anticipation of the Dialogue, we conducted a targeted literature search of white and grey literature to understand current care delivery mechanisms across acute, community, and post-acute care. We searched PubMed and Google Scholar to identify literature, guidelines, and clinical consensus documents focused on nutrition, as well as a review of nutrition-focused tools, quality measures, data sources (i.e., registries, QCDRs), quality improvement programs, and key stakeholders. In total, we performed a full review of 99 studies.

RESULTS

Multi-stakeholder input received during the Dialogue, as well as findings from the literature review, highlighted a significant opportunity to better integrate malnutrition care standards, tools, and best practices into patients' care as they transition across care settings (Figure 2).

Figure 2. Better Integration of Malnutrition Care into Care Transitions Is Necessary



To do so, participants noted the need for better screening and nutrition care, patient education and shared decision-making, and data infrastructure to support improved coordination, communication and patient engagement in addressing nutrition needs. However, participants also identified barriers inhibiting the effective delivery of nutrition care as patients transition across settings of care (Figure 3).

Figure 3. Barriers to Addressing Patients' Nutrition Needs across Care Settings

Screening & Nutrition Care

1. Lack of patient education on impact of proper/good nutrition on disease management, recovery and health outcomes
2. Perceived stigma or "blame" attached to term "malnutrition" during patient and family engagement

Patient Education & Shared Decision Making

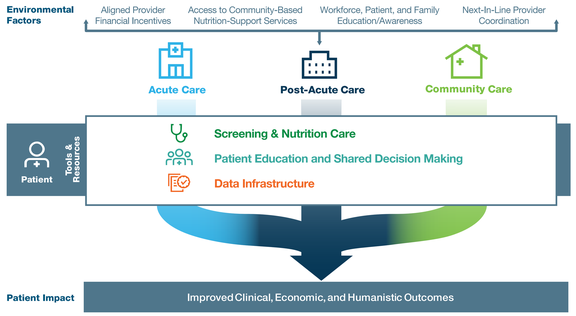
1. Nutrition risk identification and care are not integrated into existing care transition pathways and accountable care models
2. Challenges to effective screening (e.g., forgetting to screen, lack of training to screen, lack of time during the office visit)
3. Insufficient clinician knowledge of how to access and make use of other clinical and community-based support services and partners (e.g., dietitians, social workers) to address patients' malnutrition needs and lack of dedicated hours for physician training on nutrition during medical school
4. Lack of coverage for nutrition assessment, education, counseling, and treatment

Data Infrastructure

1. Lack of widespread adoption of standardized malnutrition terminology and clinical standards across care settings to support data transfer
2. Lack of published, high quality data demonstrating the impact of good nutrition on patients' outcomes in the post-acute and community settings

Understanding these barriers, Dialogue participants agreed that there is an opportunity for stakeholders to work together to better integrate patients' nutrition needs into care transitions and proposed a model to better address this issue through existing system-level care pathways (Figure 4).

Figure 4. Framework for Integrating Malnutrition Care into System-Level Care Pathways



Finally, Dialogue participants outlined key recommendations for multiple stakeholders, including patients and caregivers, policymakers, healthcare providers, and payers, to promote improved patient transitions between care settings (Figure 5).

Figure 5. Recommendations to Advance Malnutrition Care as Patients Transition Across Care Settings

CONCLUSIONS

The Dialogue outlined ways that clinicians, community and social service providers, patients and caregivers, payers, and policymakers can partner to address malnutrition care gaps and operationalize recommendations that (1) support systematic nutrition screening and care, (2) provide better education and shared decision making to patients and their caregivers, and (3) improve data infrastructure to capture and share critical nutrition information.

To implement some of these recommendations, we will establish a pilot to advance systematic identification, treatment, and management of patients who are malnourished or at risk for malnutrition as they transition across care settings. The pilot will seek to engage hospital-based teams and community-based clinicians and service providers (e.g., primary care group practices, dietitians, meal providers, and others) to integrate patient-centered nutrition care into existing care transition pathways or models. Specifically,the pilot will aim to ensure interventions and follow-ups for nutrition care are in place when patients are discharged from the hospital and to improve recognition and management of patients' nutrition risk prior to their admission to a hospital and/or as a component of chronic disease management. Other stakeholders should similarly seek to integrate optimal nutrition care into care coordination models and programs.

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