Malnutrition
In Nursing Homes

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Food Insecurity is a Problem That Often Begins Before Admission into a Nursing Facility

- Limited or uncertain access to enough nutritious food on a regular basis, or food insecurity, occurs in approximately 10 percent of households in the U.S. and is much higher among high risk, minority and other populations. Older people are particularly at risk for not having enough nutritious food to eat. You can't always tell if someone is suffering from food insecurity by their appearance.

- More than 41 Million Americans Lived in Food-Insecure Households in 2016. *Screen and Intervene: Addressing Food Insecurity Among Older Adults* -- seniorhealthandhunger.org

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10 Million+

Older adults face hunger daily, which increases their risk for chronic health conditions such as diabetes and heart disease.

One in five adults over age 50 suffers from food insecurity.

Root Cause Coalition, http://www.rootcausecoalition.org/wp-content/uploads/2017/05/Mt-Plains-Slides-1.pdf

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Addressing Food Insecurity Before Admittance to Nursing Facility Can Assist People Stay Out of Facilities

- The Food Research Action Center & AARP Foundation developed a free online course to help health care providers address senior hunger.

- Food Insecurity Can Lead to Malnutrition.

Screen and Intervene: Addressing Food Insecurity Among Older Adults -- seniorhealthandhunger.org The course is approved for 1.0 AMA PRA Category 1 Credit (for MDs and DOs).

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MALNUTRITION DEFINED

Malnutrition is “a nutrition imbalance that can affect both overweight and underweight patients. Lack of adequate calories, protein, or other nutrients needed for tissue maintenance and repair can result in malnutrition.”

Malnutrition disproportionately affects older adults.

Source: Memorandum from Agata Dabrowska, Analyst, Cong. Res. Serv., on Malnutrition in Older Adults to Hon. Bill Pascrell Jr. (Mar. 8, 2017) (on file with Cong. Res. Serv.), defeatmalnutrition.today/sites/default/files/documents/CRS_Memo_Malnutrition_in_Older_Adults.pdf.

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Cause of Malnutrition

Poor food and fluid intake is the primary cause for Long-term Care ("LTC") malnutrition as average consumption can be 50% of food offered.

Heather Keller et al., *Making the Most of Mealtimes (M3): Grounding Mealtime Interventions with a Conceptual Model*, 15 J. AM. MED. DIR. ASSOC. 158 (2014), www.ncbi.nlm.nih.gov/pmc/articles/PMC4316206/pdf/nihms658542.pdf.

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Statistics vary in studies between 20 – 50% on the number of long term care residents suffering from malnutrition, and can be even higher depending on the facility.

E.g., Matthias J. Kaiser et al., *Frequency of Malnutrition in Older Adults: A Multinational Perspective Using the Mini Nutritional Assessment*, 58 J. AM. GERIATRICS SOC'Y 1734 (2010) (summarizing study that found 50% of long term care residents malnourished.)

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Why is Malnutrition an Issue in SNF?

STAFFING PROBLEMS

Limited staff often serve residents in a rushed or unsafe manner. When workers are forced to feed residents too quickly problems with choking or malnutrition occur.

Source: NAT'L CTR. FOR HEALTH WORKFORCE ANALYSES, BUREAU OF HEALTH PROF., NURSING AIDES, HOME HEALTH AIDES, AND RELATED HEALTH CARE OCCUPATIONS -- NATIONAL AND LOCAL WORKFORCE SHORTAGES AND ASSOCIATED DATA NEEDS (2004), bhw.hrsa.gov/sites/default/files/bhw/RNandHomeAides.pdf.

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- Certified nursing assistants (CNAs) typically assist seven to nine residents eat and drink during the daytime, and as many as twelve to fifteen residents during the evening meal.

- This contrasts with the ideal of one CNA for every two to three residents who require eating assistance.

- Residents are fed quickly, or forcefully, and sometimes not fed at all.

Source: Sarah Green Burger et al., *Malnutrition and Dehydration In Nursing Homes: Key Issues In Prevention and Treatment,* NAT'L CITIZENS' COALITION FOR NURSING HOME REFORM, June 2000, at viii, www.commonwealthfund.org/~/media/files/publications/fund-report/2000/jul/malnutrition-and-dehydration-in-nursing-homes--key-issues-in-prevention-and-treatment/burger_mal_386-pdf.

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Poor Oral Health & Lack of Dental Care

- Several federal reports have called attention to the disproportionate impact of oral disease on people with disabilities.

- Lack of funding & cuts to funding for dental care for Medicaid patients in nursing homes. *Boothby v. Cal. Dept. of Health Care* – Los Angeles Superior Court held California violated federal rules in cutting compensation for periodontal maintenance, the standard of care for people with serious gum diseases.

- Dentures frequently lost & Medicaid covers cost every 5 years.

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Deficiency of Care Still Exists . . .

According to a report by the Kaiser Family Foundation:

- In 2015, more than one in five nursing facilities received a deficiency for actual harm or jeopardy to a nursing facility resident.
- Between 2009 and 2013, the average number of deficiencies per facility declined from 9.33 to 7.28, though there was a slight increase between 2013 and 2015, with average deficiency of 8.60 in 2015.
- Similarly, the share of facilities with no deficiencies increased slightly from 2011 (7%) to 2013 (8%) then dropped by 2015 (7%).

Source: Charlene Harrington et al., *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2015* , KAISER FAM. FOUND. (2017), files.kff.org/attachment/REPORT-Nursing-Facilities-Staffing-Residents-and-Facility-Deficiencies-2009-2015.

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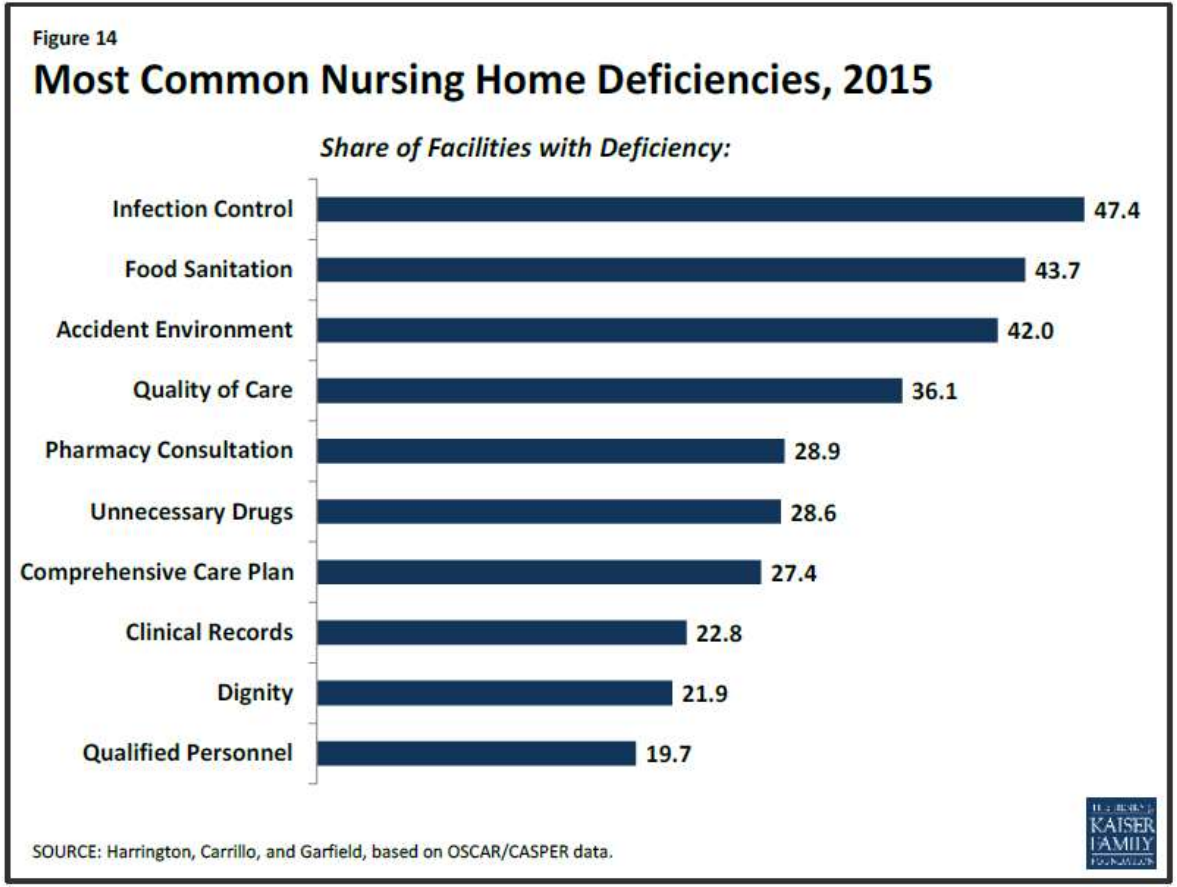

Source: Charlene Harrington et al., *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2015* , KAISER FAM. FOUND. (2017), files.kff.org/attachment/REPORT-Nursing-Facilities-Staffing-Residents-and-Facility-Deficiencies-2009-2015.

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California Is No Exception To The Trend

A recent nursing doctoral project in looked at data from four SNFs in Southern California and examined eighty patients. Seventy-six percent (76%) of those patients were found to be suffering from some form of malnutrition.

Source: Krystal Marie Harding, Prealbumin as a Malnutrition Indicator in Elderly Patients Admitted to a Skilled Nursing Facility 1 (May 2014) (unpublished doctoral project) (on file with Cal. State Univ. Fullerton), nursing.fullerton.edu/programs/pdf/dnp/finalprojects/2014/Harding_Approved_FinalDNPProject.pdf.

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Red Flags to Look For

- Unintended and excessive weight loss of >5% in one month or >10% over a six month period.

  ➔ Excessive, rapid weight loss may be a sign of depression, medical, or dental problems that make eating difficult or cause refusal to eat. At the same time, it may be a sign of problems with nutritional care within the nursing home.

- Chronic diseases (e.g. cancer, diabetes, depression, and chronic obstructive pulmonary disease (COPD)) and functional impairments that may impair proper nutrition and hydration and requires staff intervention.

- Swallowing disorders

Source: NAT'L QUALITY MEASURES CLEARINGHOUSE (NQMC), MEASURE SUMMARY: LONG-STAY NURSING HOME CARE: PERCENT OF RESIDENTS WHO LOSE TOO MUCH WEIGHT (2015), www.qualitymeasures.ahrq.gov/summaries/summary/50061/longstay-nursing-home-care-percent-of-residents-who-lose-too-much-weight#.

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- Tooth loss and oral disease compromising the ability to eat, bite, chew, or swallow food.

- Medications with side effects of nausea, anxiety, constipation, and lack of appetite.

Sources: U.S. DEP'T OF HEALTH & HUM. SERVS., NAT'L INST. OF DENTAL & CRANIOFACIAL RES., NAT'L INSTS. OF HEALTH, *ORAL HEALTH IN AMERICA: A REPORT OF THE SURGEON GENERAL* 6-7 (2000), https://www.nidcr.nih.gov/research/data-statistics/surgeon-general; NAT'L QUALITY MEASURES CLEARINGHOUSE (NQMC), MEASURE SUMMARY: LONG-STAY NURSING HOME CARE: PERCENT OF RESIDENTS WHO LOSE TOO MUCH WEIGHT (2015), www.qualitymeasures.ahrq.gov/summaries/summary/50061/longstay-nursing-home-care-percent-of-residents-who-lose-too-much-weight#.

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- Depression — which has been identified as the "most common reversible illness" associated with malnutrition.

- Dehydration — a major factor of weight loss in about 10% of nursing home residents.

- Positioning of resident during feeding.

- Changes in appetite.

Sources: NAT'L QUALITY MEASURES CLEARINGHOUSE (NQMC), MEASURE SUMMARY: LONG-STAY NURSING HOME CARE: PERCENT OF RESIDENTS WHO LOSE TOO MUCH WEIGHT (2015), www.qualitymeasures.ahrq.gov/summaries/summary/50061/longstay-nursing-home-care-percent-of-residents-who-lose-too-much-weight#; Neva L. Crogan et al., *Improving Nutrition Care for Nursing Home Residents Using the INRx Process*, 25 J. OF NUTR. FOR THE ELDERLY 89 (2006), www.ncbi.nlm.nih.gov/pmc/articles/PMC2583249/pdf/nihms-70443.pdf.

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Consequences of Malnutrition

"Under-nutrition is associated with **infections** (including urinary tract infections and pneumonia), pressure ulcers, anemia, hypotension, **confusion and impaired cognition**, decreased wound healing, and hip fractures. Undernourished residents become weak, fatigued, bedridden, apathetic, and depressed. When hospitalized for an acute illness, malnourished or dehydrated residents suffer **increased morbidity,** and require longer lengths of stay. Compared with well-nourished hospitalized nursing home residents, they have a five-fold increase in mortality in the hospital."

Source: Sarah Green Burger et al., *Malnutrition and Dehydration In Nursing Homes: Key Issues In Prevention and Treatment,* NAT'L CITIZENS' COALITION FOR NURSING HOME REFORM, June 2000, at vii, www.commonwealthfund.org/~/media/files/publications/fund-report/2000/jul/malnutrition-and-dehydration-in-nursing-homes--key-issues-in-prevention-and-treatment/burger_mal_386-pdf.

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Fiscal Impact

The economic impact of malnutrition is enormous. It is estimated that disease-associated malnutrition costs the U.S. $157 billion each year. Other research points to a 300 percent increase in healthcare costs that can be attributed to poor nutrition status.

Source: Robert B. Blancato, *Senior Malnutrition: A National Nutrition Crisis*, HUFFINGTON POST (May 10, 2015), www.huffingtonpost.com/robert-b-blancato/senior-malnutrition-a-nat_b_6832238.html.

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FEDERAL REGULATIONS

42 C.F.R. § 483.60 — Food & Nutrition Services

42 C.F.R. § 483.60 requires nursing homes to provide each resident with a nourishing, palatable, and well-balanced diet that meets dietary requirements and any special dietary needs.

THERAPEUTIC DIETS

The attending physician must order the therapeutic diets but the physician can delegate the task of prescribing to a registered or licensed dietician if permitted by state law. *See* 42 C.F.R. § 483.60(e).

- The facility must either employ or contract a qualified dietician. If the dietician does not work full-time, the facility must have a certified food service or dietary manager who frequently receives consultation from a qualified dietician. The facility must also employ sufficient staff to perform "the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at § 483.70(e)." *See* 42 C.F.R. § 483.60(a).

- A member of the dietary team must be part of the interdisciplinary team. 42 C.F.R. § 483.60(b).

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Menus must meet the nutritional needs of residents, be based on menus prepared in advance, be followed, be updated periodically, be reviewed by the dietician for nutritional adequacy, and must reflect reasonable efforts to cater to the resident's religious, cultural and ethnic needs, and input. *See* 42 C.F.R. § 483.60(c).

The food must be prepared in away that preserves their nutritive value, appearance, and flavor, be palatable and attractive, served at the right temperature, and "prepared in a form designed to meet individual needs." Food substitutes "of similar nutritive value" must be offered to residents who refuse to eat the food initially served. Facility must also provide water and liquids consistent with resident's needs and preferences to ensure sufficient hydration. *See* 42 C.F.R. § 483.60(d).

The resident must be served at least 3 meals a day, "at times comparable to normal mealtimes in the community"; no more than 14 hours shall elapse from the last substantial meal of the evening to the first meal of the morning. If the resident is offered a "nourishing" snack at bedtime, 16 hours may elapse between the last evening meal and the first morning meal but only if the residents agree to this meal schedule. *See* 42 C.F.R. § 483.60(f).

The facility must provide special eating equipment and utensils for residents who need them. *See* 42 C.F.R. § 483.60(g).

Paid feeding assistants must meet requirements set forth in this subsection if the facility is going to utilize them. *See* 42 C.F.R. § 483.60(h).

Sanitary conditions must be preserved. Specifically, the food must be obtained from sources approved as satisfactory by Federal , State, or local authorities; must be stored, prepared, distributed, and served under sanitary conditions, and the facility must dispose of garbage and refuse properly. *See* 42 C.F.R. § 483.60(i).

42 C.F.R. § 483.25(g) — Feeding Tubes

- Feeding tubes should be used a last measure; if a resident can still swallow and is still able to get sufficient nutrition then a tube is not needed.

- A tube can be used if there is a demonstrable medical need to prevent malnutrition or dehydration.

- The facility must try to "restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers."

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CALIFORNIA REGULATIONS

Cal. Code Regs. tit. 22, § 72335

California requires nursing homes to:

- Provide at least 3 meals a day; no more than 14 hours between the evening meal and next day's first meal.
- Offer bedtime snacks
- Offer food/meal substitutes if the resident refuses food.
- Accommodate food preferences as much as possible.
- Provide table service to residents who can and want to eat at the table
- "maintain a written plan, adequate space, equipment and food supplies to provide patients' food service in emergencies"
- Serve food "attractively, at appropriate temperatures with appropriate eating utensils and in a form to meet individual needs."

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- Make available and use "[r]ecipes for all items that are prepared for regular and therapeutic diets . . . to prepare attractive and palatable meals, in which nutritive values, flavor and appearance are conserved."

- Maintain a current profile card "indicating diet order, likes, dislikes, allergies to foods, diagnosis and instructions or guidelines to be followed in the preparation and serving of food for the patient."

- Ensure that all regular and therapeutic diets are "prescribed by a person lawfully authorized to give such an order. Verbal orders may be received and recorded by a qualified dietitian and shall be signed by the prescriber within five days."

ADEQUATE STAFFING

- Facilities must have enough nursing staff and other personnel (e.g. nurse aides) to meet the needs of each resident at all times. *See* 42 C.F.R. § 483.35; CAL. HEALTH & SAFETY CODE §1599.1(a); 22 C.C.R. §§ 72329(a) & 72501(e).

- California specifically requires a minimum 3.2 hours of nursing care, per resident, for skilled nursing facilities. CAL. HEALTH & SAFETY CODE § 1276.5(a).

- The facility must clearly display everyday the total number and the actual hours worked by both licensed and unlicensed RNs, LVNs and CNAs, and the resident census. *See* 42 C.F.R. § 483.35(g).

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All states must at a minimum comply with federal requirements. The University of Minnesota maintains a database of all states dietary regulations. To find your states nursing home dietary requirements.

See, UNIV. OF MINN., NH REGULATIONS PLUS: DIETARY SERVICES, www.hpm.umn.edu/nhregsplus/NH%20Regs%20by%20Topic/Topic%20Dietary%20Services.html (last visited March 20, 2018).

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Many states have elder abuse protection statutes that define neglect to include malnutrition issues. As an example, California's Elder Abuse and Dependent Adult Civil Protection Act (EADACPA) defines "neglect" as a failure to provide care, and includes such things as:

(1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter

(2) Failure to provide medical care for physical and mental health needs . . .

(3) Failure to protect from health and safety hazards

(4) Failure to prevent malnutrition or dehydration

CAL. WELF. & INST. CODE § 15610.57(b).

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CASE STUDIES

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***Scampone v. Grane Healthcare Co.*,**

11 A.3d 967 (Pa. Super. Ct. 2010) *aff'd on other grounds*, *Scampone v. Highland Park Care Ctr.*, LLC, 57 A.3d 582 (Pa. 2012).

- At 88 years old, Mrs. Scampone was admitted to Highland Park Care Center, a nursing home.
- Mrs. Scampone had a medical history of: senile dementia, depression, hypertension, atrial fibrillation, chronic obstructive pulmonary disease, diverticulosis, osteoporosis, diverticulitis, thoracic compression fracture, and a left hip replacement.
- Mrs. Scampone was initially hospitalized with a UTI diagnosis. A month and a half later, she was re-admitted and diagnosed with dehydration, malnutrition, and bed sores. She died of a heart attack nine days later.

The Lawsuit

- The executor of Mrs. Scampone's estate sued the nursing home, its owners, and the managing company alleging that their substandard care caused dehydration, and malnutrition which in turn caused the heart attack.

- The plaintiff asserted that chronic understaffing was a problem at the nursing home and employees could not provide the appropriate care needed for the residents and the defendants were corporate and vicariously liable. Punitive damages were sought. Testimony at the trial showed understaffing.

Trial

- Nurse 1 also received many complaints about the unavailability of CNAs. The CNAs told him they didn't have enough time to give patients water and to respond to call lights.
- There were delays in feeding, patients were not receiving medications, and the patients' waters were out of reach.
  - Management ignored both nurses' and nursing assistants' complaints of understaffing.
  - Lack of nursing notes in files for a 19-day period between January 7 to 26, 2004.
- Confusion is a symptom of dehydration.
- The jury determined that the nursing home was both corporately and vicariously liable for Mrs. Scampone's death.

California Case

- Decedent, CR was admitted to a nursing facility in Southern California.
- At time of admittance CR was 84, weighed 121 pounds, and was dependent on staff for assistance to dress himself and move about the facility.
- Facility knew CR was at risk of dehydration and weight loss.

California Case

- Decedent's plan of care required staff to ensure that Decedent consume at least 80% of meals.
- Notes indicated decedent did not consume required amounts.
- Multiple staff members unaware decedent could not feed himself.
- When Decedent transferred to a hospital 5 months later his weight dropped to 102 pounds.
- Decedent died shortly thereafter.

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California Case

- Facility sued for negligence, elder abuse and neglect, violation of California Patients' Bill of Rights (CAL. HEALTH & SAFETY CODE § 1430), and wrongful death. Case settled.

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Examples of State Issued Citations

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For example,

California Department of Public Health (CDPH), 6/19/2015, Citation No. 95-2268-0011518-S

The facility was fined $100,000 because a resident died from choking in 2014. Resident had a history of choking and needed to be adequately supervised during meals but facility failed to do so.

The resident previously had a choking incident in 2012 and needed to be hospitalized. She again choked in 2013.

Interventions That Help Curb the Threat of Malnutrition

- **Alleviate dry mouth**: Instruct patients with dry mouth to avoid caffeine; alcohol and tobacco; and dry, bulky, spicy, salty, or highly acidic foods. Actions the patient can take include eating sugarless hard candy or chewing gum to stimulate saliva (not appropriate for patients with dementia or dysphagia), applying petroleum jelly to the lips and dentures, and taking frequent small mouthfuls of water.

INTERVENTIONS

- Walk around at mealtimes to determine how much food is being consumed and whether assistance is needed.
- Take your breaks before or after mealtimes, whenever possible, to ensure that adequate staff are available to help patients with meals.
- Encourage family members to visit at mealtimes. Ask them to bring favorite foods from home, as long as they are in keeping with the patient's diet. Ask about the patient's food preferences.

Interventions

- Suggest small, frequent meals with adequate nutrients to help patients regain or maintain weight. Ask dietary services to provide nutritious snacks.
- Remove bedpans, urinals, and emesis basins from rooms before mealtimes.
- Administer analgesics (designed to prevent pain) and antiemetics (designed to prevent nausea) on a schedule that will diminish the likelihood of pain or nausea during mealtimes.

Interventions

- Serve meals to patients in a chair if they can comfortably get out of bed and remain seated.
- Sit at the patient's eye level and make eye contact when feeding her to create a more relaxed atmosphere.
- Don't interrupt patients for rounds and non-urgent procedures during mealtimes.

- Rose Ann DiMaria-Ghalili & Elanie Amella, *Nutrition in Older Adults: Intervention and assessment can help curb the growing threat of malnutrition*, 105 AJN 40-50 (2005), journals.lww.com/ajnonline/Fulltext/2005/03000/Nutrition_in_Older_Adults__Intervention_and.20.aspx

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Supplements

- Give patients a choice of supplements to increase personal control.
- If client is unwilling to drink a glass of liquid supplement, offer 30 ml per hour in a medication cup and serve it like medicine.
- Offer liquid energy supplements, unless medically contraindicated.
- Permit self-selected seasonings and foods.
- Play relaxing dinner music during mealtime.

Source: Nic Noc, *Nursing Interventions and Rationales*, BLOG (July 21, 2013), nursinginterventionsrationales.blogspot.com/2013/07/imbalanced-nutrition-less-than-body.html

Contact AARP Foundation Litigation (AFL)

If you're considering litigation or other advocacy options regarding malnutrition issues in nursing homes. We are available to consult or co-counsel with you.

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MALNUTRITION IN NURSING HOMES

Ombudsman Perspective

LONG-TERM CARE OMBUDSMAN

Advocates for residents residing in long-term care facilities

Federal and State mandated program

Older Americans Act program

OMBUDSMAN RESPONSIBILITIES

Identify, investigate and resolve complaints made on behalf of residents

Educate residents and consumers on their rights and facility regulations

Provide consultations to facility staff

Conduct unannounced monitoring visits to nursing homes and assisted living

Monitor the quality of care provided by a health care business which has filed for bankruptcy & report findings to the court

Individual and systemic level advocacy

Client centered and focused advocacy

Consent based program

Community education

ISSUES AN OMBUDSMAN CAN ADDRESS

Those related to quality of care and quality of life

Questions about what services should be provided

Concerns involving the rights of residents and family members

Matters of dignity and respect

LOS ANGELES LTCO DATA 2016-2017

Closed 12,022 cases

Closed 16,492 complaints

Unannounced visits to nursing homes 6,223

Unannounced visits to assisted living or board and cares 3,674

Information sessions with consumers 3,705

Consultations with facility staff 800

Hours donated by volunteers 13,233

TOP FIVE COMPLAINTS IN LOS ANGELES

Top five long term care facility complaints handled by the ombudsman program:

1) Resident to Resident Physical or Sexual Abuse

2) Inappropriate Discharges or Evictions

3) Gross Neglect

4) Failure to Respond to Requests of Assistance

5) Physical Abuse

NATIONAL LTCO DATA 2015

https://agid.acl.gov/DataGlance/NORS/

Closed 199,238 complaints

Closed 129,559 cases

Information sessions with consumers 334,627

Consultations with facility staff 104,201

Hours donated by volunteers 708,323

NATIONAL TOP FIVE COMPLAINTS

Five most frequent nursing facility complaints handled by ombudsman programs:

1) Improper eviction or inadequate discharge/planning

2) Unanswered requests for assistance

3) Lack of respect for residents, poor staff attitudes

4) Administration and organization of medications

5) Quality of life, specifically resident/roommate conflict

HOW CAN AN OMBUDSMAN HELP?

WHAT ISSUES IMPACT MALNUTRITION?

Food quality

Dietary concerns

Weight loss due to inadequate nutrition

Lack of assistance with eating

Over use of chemical restraints

Staffing shortages

Gross neglect

Dental services

Fluid availability

Insufficient funds to operate

Eating assistants

COMPLAINT MANAGEMENT

Investigating and addressing complaints brought to the ombudsman's attention

Ombudsman identified complaints during unannounced visits

Ombudsman familiarity with residents and observing changes in condition

Record review, speaking with facility staff, attending care plan meetings

Referring to the regulatory agencies that have nursing staff to determine if weight loss and malnutrition is avoidable or unavoidable

Referring to State DOJ or Office of the Inspector General for gross neglect cases

Referrals provided to residents and families to civil litigators if appropriate

MEDICAL RECORDS REVIEW

In the course of an investigation medical records may need to be reviewed to determine weight loss, care plan in place to address issues that relate to malnutrition, care plan being followed, percentage of meals eaten daily, swallow assessments needed

Facility records, hospice records, and hospital records may be reviewed

Ombudsman have access rights to records and can help residents and some family members gain access

Ombudsman can include those records in referrals to regulatory agencies, professional boards, local state and federal law enforcement. They can be disclosed in civil litigation with proper consent

EDUCATION AND SUPPORT

Ombudsman participation in care plan meetings to help residents and family members understand:

- Medical conditions
- To question weight loss in the context of medical conditions
- To ensure that dental matters are addressed
- To determine if the care plan addresses need for assistance with eating
- To address medication issues
- Formula for g-tube feeding levels
- To determine who to go to between care plans to address concerns
- To determine if the care plan is being followed

COMMUNITY RELATIONSHIPS

Ombudsman outreach and relationship development

To improve resident care through educating allied professionals on the rights of residents and responsibilities of facilities to provide a standard of care and

To develop referral sources with:

Hospitals

Health plans

Fire departments

Law enforcement

Coroners office

Other professionals who are potential referral sources

CONTACT INFO

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Malnutrition in Nursing Homes

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Introduction

- Here to talk about some policy thoughts around malnutrition in nursing homes
- One way to achieve policy change is to work together

Bringing the Issue of Malnutrition to Policymakers…

defeatmalnutrition.today

…vital to healthy aging

Our Members

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Abbott Nutrition

Academy of Nutrition and Dietetics

AgeWell Senior Services

Alliance for Aging Research

Altarum Institute Center for Elder Care and Advanced Illness

Alzheimer's Foundation of America

American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.)

American Society on Aging

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Area Agency on Aging 3 (Lima, OH)

Benjamin Rose Institute on Aging

Berks Encore

Caregiver Action Network

Chautauqua County Office for the Aging

Community Servings

Elder Justice Coalition

Feeding America

Generations United

The Gerontological Society of America

God's Love We Deliver

Healthcare Nutrition Council

Helping Hands of Las Vegas Valley

Hunger Free America

International Council on Active Aging

Latino Integrative Nutrition Initiative (LINI)

LifeCare Alliance

MANNA

Maryland Department of Aging

MAZON: A Jewish Response to Hunger

Meals on Wheels America

Meals on Wheels Association of Pennsylvania

Meals on Wheels Fairfield County

Meals on Wheels of Lehigh County

Medicaid Health Plans of America

MidPen Resident Services

NACOG AAA

National Alliance for Caregiving

National Association of Area Agencies on Aging (n4a)

National Association of Nutrition and Aging Services Programs (NANASP)

National Board of Physician Nutrition Specialists

National Black Nurses Association

The National Caucus and Center on Black Aging

The National Consumer Voice for Quality Long-Term Care

National Council on Aging

National Foundation to End Senior Hunger

National Grange

National Hispanic Council on Aging

National Hispanic Medical Association

National Indian Council on Aging

National Medical Association

National Minority Quality Forum

National Recreation and Park Association

National Silver Haired Congress

Nestle Health Science

NETWORK

Philadelphia Corporation for Aging

Project Angel Food

PurFoods/Mom's Meals

RetireSafe

SAGE - Services and Advocacy for GLBT Elders

Salvation Army

Senior Nutrition Program- Santa Clara County

SeniorServ

Society for Nutrition Education and Behavior

State of NC's OAA Nutrition Services

Textured Food Innovations

Veterans Health Council

VNA Meals on Wheels

Washoe County Social Services, Senior Nutrition Services

West Health

Western Reserve AAA

What Have We Accomplished?

- Have become a resource to Congress and members of the media on malnutrition
- Held webinars and a Congressional advocacy day
- Submitted comments to CMS
- Supported malnutrition electronic clinical quality measures
- Written a review article on malnutrition in federal policy
- Participated in national, state and local conferences
- Advocated for malnutrition measures, commissions and other groups in Massachusetts, Ohio, Virginia, and Florida
- Worked with Members of Congress on increased nutrition funding, a GAO report, and other nutrition issues
- Released a *State Legislative Toolkit*
- And, our biggest project to date…


National Blueprint:
Achieving Quality
Malnutrition Care for
Older Adults
Avalere
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Contributing Factors of Malnutrition among Older Adults Illustrate the Need for a Coordinated, Comprehensive Solution

The Malnutrition Quality Collaborative Had Two Main Objectives

1. To advance health and quality-of-life outcomes among older adults by increasing national awareness of malnutrition.

2. To engage national, state, and local healthcare stakeholders to take action to better prevent, identify, and treat malnutrition.

Through *the Blueprint*, The Collaborative aimed to support development of comprehensive strategies to improve malnutrition care across all care settings for older adults

The 4 Goals and Supporting Strategies of the *National Blueprint: Achieving Quality Malnutrition Care for Older Adults*

Goals	Goal 1: Improve Quality of Malnutrition Care Practices	Goal 2: Improve Access to High-Quality Malnutrition Care and Nutrition Services	Goal 3: Generate Clinical Research on Malnutrition Quality of Care	Goal 4: Advance Public Health Efforts to Improve Malnutrition Quality of Care
Strategies	1. Establish Science-Based National, State, and Local Quality Goals 2. Identify Quality Gaps in Malnutrition Care 3. Establish and Adopt Quality Malnutrition Care Standards 4. Ensure High-Quality Transitions of Care	1. Integrate Quality Malnutrition Care in Payment and Delivery Models and Quality Incentive Programs 2. Reduce Care Coordination and Financial Alignment Barriers 3. Strengthen Nutrition Professional Workforce	1. Evaluate Effectiveness and Impact of Best Practices on Patient Outcomes and Clinical Practice 2. Identify and Fill Research Gaps by Conducting and Disseminating Relevant Research 3. Track Clinically Relevant Nutrition Data	1. Train Healthcare Providers and Administrators on Malnutrition Care Quality 2. Educate Older Adults & Caregivers on Malnutrition Impact, Prevention, Treatment and Available Resources 3. Educate and Raise Visibility with National and State Policymakers 4. Integrate Malnutrition Care Goals in National, State, and Local Population Health Management Strategies 5. Allocate Education and Financial Resources to HHS and USDA-administered Food and Nutrition Programs

Achieving These Goals Requires Action Today

The Blueprint recommendations highlight **cross-cutting actions for key healthcare stakeholders**:

- National, state, and local government agencies
- Healthcare practitioners, healthcare institutions, and medical professional societies
- Individuals, families, caregivers, patient advocacy groups, and aging organizations
- Public and private payers

A Sampling of Relevant Action Steps from the Blueprint: Post-Acute Setting

- Collaborate with acute care providers to develop a protocol or care pathway that directly links malnutrition patient data and discharge plans to the post-acute care setting
- Identify certified providers to support malnutrition screening, assessment, and follow-up in post-acute care settings when a dietitian is not available
- Define care pathways and staff responsibilities to ensure that patients receive optimal malnutrition care and care planning

Lessons from Acute Care

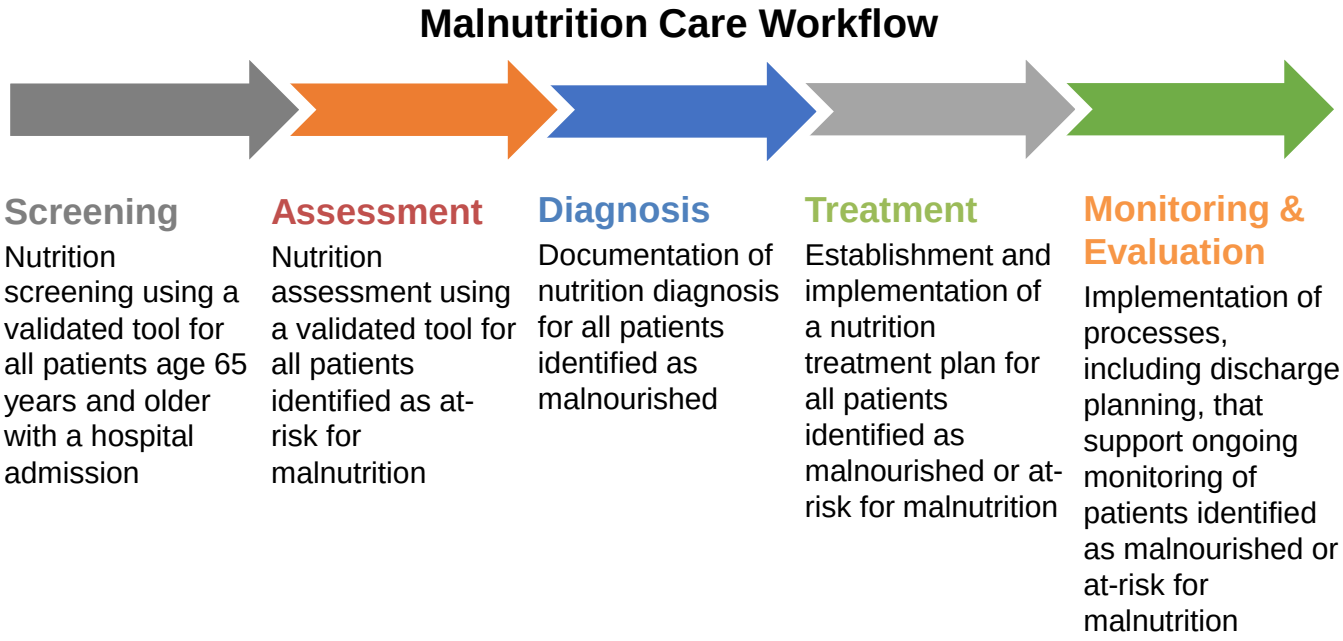
- Acute care has made more progress than post-acute care in the malnutrition space
- Most notably, the MQii and its related quality measures…

What is the Malnutrition Quality Improvement Initiative (MQii)?

- Developed by the Academy of Nutrition and Dietetics and Avalere Health
- MQii objectives:
  - Develop malnutrition quality measures “that matter”
  - Improve malnutrition care with an interdisciplinary care team roadmap (toolkit)
  - Advance tools that can be integrated into EHR systems to improve care quality

The MQII is focused on older adults (ages 65 and older), given the significant impact malnutrition has on this patient population and the opportunity to improve care among these patients

The MQii Offers a Solution to Enhance the Quality of Malnutrition Care



CMS Quality Measures

Academy of Nutrition and Dietetics and Avalere Health submitted four malnutrition electronic clinical quality measures to CMS in 2016

Quality measures are tools that help measure and track the quality of services that healthcare professionals provide

In August 2017, it was announced that CMS would consider adding these measures “in the future”

Advocates are working with CMS on new efforts

Potential Exists!

- There’s potential for lessons learned for nursing home care here too
- Could partner with post-acute care facility accreditation organizations to adopt malnutrition care quality measures or involve malnutrition in award requirements
- Need to develop what the specific outcome targets would be to help evaluate this success

Implementing these recommendations requires **collaboration across all sectors**

Without collaborative work going forward, it will be impossible to **implement comprehensive solutions** to the crisis of older adult malnutrition, which is what this issue requires—**a coordinated, carefully integrated approach**.

Conclusions

Join Us In Helping to Defeat Malnutrition

- Determine the role you can play to improve the quality of malnutrition care among older adults!
- Go to defeatmalnutrition.today
- mponder@matzblancato.com