Policy Opportunities for Nutrition Care and Healthy Aging:

A Toolkit for Federal Legislators

Women in Government

defeat malnutrition today

About Defeat Malnutrition Today

The Defeat Malnutrition Today coalition is a diverse alliance of over 100 national, state, and local stakeholders and organizations, including community, healthy aging, nutrition, advocacy, healthcare professional, faith-based, and private sector groups. The coalition shares the goal of achieving the recognition of malnutrition as a key indicator and vital sign of older adult health risk; it works to create policy change toward a greater emphasis on screening, detecting, diagnosing, treating, and preventing malnutrition.

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About Women In Government (WIG)

Women In Government is a national, non-profit, non-partisan organization of women state legislators. Women In Government has provided leadership opportunities, networking, expert forums, and educational resources for more than 30 years on policy issues such as education, energy, the environment, healthcare, technology, transportation, and more.

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Dear Federal Legislator:

As you work to support your constituency, balance budgets, and advocate for comprehensive federal healthcare strategies, taking policy actions on nutrition is an important area to consider. Nutrition is an issue that impacts all constituents, their ability to age in good health, and their healthcare costs. It is particularly critical for our nation's older adults; older adult malnutrition is a growing crisis in America today. The cost of disease-associated malnutrition in older adults is high—estimated to be $51.3 billion per year.[1] Up to one out of two older adults is either at risk of becoming or is malnourished, yet insufficient attention is given to preventing or treating the condition.

Malnutrition, particularly lack of adequate protein, is a patient safety risk and can have deleterious effects on health, especially when other medical conditions are present. Specifically, it can increase mortality rates, readmission rates, and complication rates such as increased length of stay and cost of care. But it is also preventable. With effective screening, assessment, diagnosis, and intervention, malnutrition can be identified and addressed to benefit older adults and health outcomes.

The COVID-19 pandemic has greatly impacted our social determinants of health. It has increased the challenges for already vulnerable populations and revealed the increased need for strengthened systems and policies to support them. Because of the pandemic, many older adults isolated themselves, which may have limited their access to food, particularly healthy food. Many older adults also face food insecurity. Prior to the pandemic, Feeding America reported that 7.3% of older adults were food insecure and 2.7% were very low food secure. This translated into 5.3 million and 2.0 million older adults facing food insecurity or very low food security[2] In addition, the COVID-19 pandemic has exacerbated the longstanding disparities in food insecurity. Black and Latino adults have been more than twice as likely as white adults to report that their households did not get enough to eat.[3] COVID-19 relief packages provided much needed increases for federal nutrition programs which have helped address food insecurity and food access. However, recent reports underscore that the spending increases need to be made permanent[4,5] because these programs have historically not kept pace with higher food costs and older adults' greater needs, which have been even further elevated by the pandemic.

A collaborative effort among key stakeholders and advocates in the public and private sectors is required to reduce and prevent malnutrition among older adults across the country. The Defeat Malnutrition Today coalition and its more than 100 members along with Women In Government are proud to offer you this toolkit. It is hoped that the policy actions presented will help provide the framework necessary to achieve success in preventing and treating malnutrition among older adults; progress is being made (Appendix A), but more action is needed. We encourage you to use this toolkit to raise awareness about malnutrition and develop policies and implement feasible solutions to combat this public health crisis affecting so many older adults and their families in America today.

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Table of Contents

Top-line Summary 5

Quality Malnutrition Care as a Public Health Issue 6

The Cost of Malnutrition 9

Social Determinants of Health and Nutrition 10

A Blueprint for Success in Achieving Quality Malnutrition Care 12

Policy Opportunities to Address Older Adult Malnutrition 14

A Quality Focus for Malnutrition Care 17

Conclusion and Call to Action 18

Appendices 19

Appendix A: Malnutrition Policy Through the Decade 19

Appendix B: Stakeholders and Resources for Older Adult Meals and Food Assistance 21

Appendix C: Medical Nutrition Therapy Act of 2021 22

Appendix D: Federal Nutrition Assistance Programs Serving Older Adults and Opportunities for Federal Legislators 24

Appendix E: Sample Malnutrition and Food Insecurity Screening Tool 25

Appendix F: Glossary of Terms 27

Resources 29

References 31

Top-line Summary

What is Malnutrition?

Malnutrition = imbalance in energy, protein, or other nutrients that adversely impacts an individual's own body form, function, and clinical outcomes.[6]

Older adult malnutrition is a growing crisis

- Up to one out of two older adults is either at risk of becoming or is malnourished[7,8]
- Disease-associated malnutrition in older adults is estimated to cost $51.3 billion annually[1]

Malnutrition is a patient safety risk and can impact health outcomes and health equity

- According to the Academy of Nutrition and Dietetics[9]:
  - Between 20% and 50% of adults are at risk of becoming or are malnourished upon admission to the hospital, yet only 8% are diagnosed
  - The gap occurs for a number of reasons, including how malnutrition care information is tracked in electronic medical record systems
  - Malnourished hospitalized patients are up to five times more likely to have an in-hospital death and have a 54% higher likelihood of hospital 30-day readmissions, compared to non-malnourished patients, according to two recent AHRQ Hospital Cost Utilization Project analyses
  - The cost per readmission for patients with malnutrition (versus patients readmitted without malnutrition) was $17,500—26%-34% higher, depending on the specific type of malnutrition
- Malnutrition is highest in Black, older adult, and poor communities[10]
- Yet malnutrition is often not identified or treated.

Malnutrition care is recognized as an important gap area[11]

- However, there are no federal public health goals, such as Healthy People 2030, that address malnutrition. Malnutrition quality measures are not included in Centers for Medicare & Medicaid Services (CMS) quality incentive programs and CMS provides medical nutrition therapy coverage for only a limited number of conditions
- *The National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update* identifies specific areas of stakeholder collaboration that can help raise awareness about and tackle the issue of malnutrition[11]
- COVID-19 has revealed the importance of telehealth as an opportunity to stay connected to patients. Telehealth connects registered dietitian nutritionists (RDNs) with patients who may be at risk for malnutrition or are already malnourished.

Malnutrition policy actions are needed now!

Proactive legislative and public health policy actions can help ensure quality malnutrition care is included in strategies that promote effective patient safety, preventive services, care transitions, and population health and health equity for older adults.

How to address older adult malnutrition

Acute and post-acute care

- Adopt a required malnutrition care measure in CMS quality incentive programs across the spectrum of care, including in the Medicare inpatient acute care reporting system, as called for in this statement in the October 8, 2021 Congressional Record
- Integrate malnutrition care in any permanent expansion of telehealth services
- Add malnutrition care training to health professional training curricula

Community

- Pass legislation to expand access to medical nutrition therapy, specifically S.1536, the Medical Nutrition Therapy Act of 2021
- Pass legislation to increase funding for congregate and home- delivered nutrition programs
- Operationalize legislation that included malnutrition in Older Americans Act reauthorization
- Urge guidance, oversight, and education for congregate and home-delivered meals providers to better meet specific nutrition and chronic disease needs of older adults
- Increase information and encouragement for older constituents to sign up for federal nutrition programs

Public health

- Add malnutrition screening/monitoring questions to national surveys of older adults
- Expand research base on older adult nutrition needs and impact of malnutrition on health outcomes and equity
- Expand focus on older adult malnutrition in the 2025-2030 Dietary Guidelines for Americans as called for in this US Government Accountability Office report on Nutrition Assistance Programs

Quality Malnutrition Care as a Public Health Issue

(Adapted from *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*)[11]

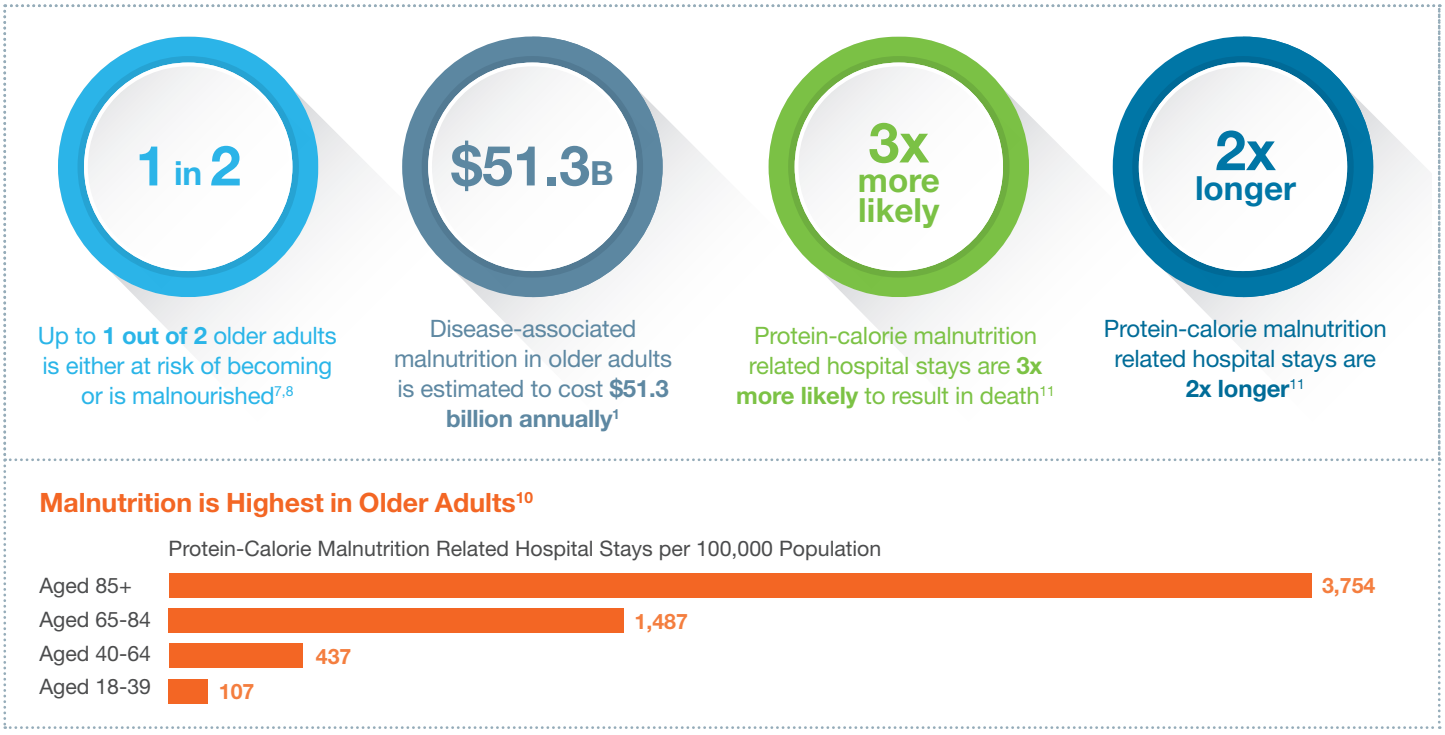
High-quality nutrition and malnutrition care for older adults should be at the top of the federal agenda as we develop population health strategies to improve health and to deliver consistent quality healthcare at an affordable cost and tackle social determinants of health and health equity.

An increasing body of statistics and health economics data shows the costs in human and economic terms of malnutrition among this age group (Figure 1). With the number of adults aged 65 years and older expected to reach 77 million by 2034, and Medicare spending projected to rise at a higher rate than overall health spending, there is an urgency to secure the future of "healthy aging," starting with nutrition.

Nutrition has been referred to as a vital sign of older adult health. Good nutrition has been shown to help support a healthy and active lifestyle, improve health outcomes, and reduce healthcare costs. In stark contrast, malnutrition, particularly the lack of adequate protein, calories, and other nutrients needed for tissue maintenance or repair, has been shown to be associated with poor health outcomes, frailty and disability, and increased healthcare costs. A Congressional Research Service report cited evidence that malnutrition affects 35-50% of older residents in long term care facilities and as many as 60% of hospitalized older adult patients.[12] However, a Healthcare Cost and Utilization Project report comments malnutrition is only diagnosed in about 8% of hospital stays.[13] Importantly, malnutrition is a significant problem for both underweight and overweight or obese individuals due to loss of lean body mass. Moreover, generally when people reference malnutrition, it is protein-energy malnutrition.

The causes of malnutrition are multiple and complex, and the solutions require collaboration among many government bodies, organizations, and communities. To coalesce the key stakeholders and focus additional attention on older adult malnutrition, the Defeat Malnutrition Today coalition (www.defeatmalnutrition.today) and Women In Government (www.womeningovernment.org) developed and created this Toolkit for Federal Legislators.

Figure 1: Malnutrition is a Critical Public and Patient Safety Issue



Poverty and food insecurity significantly increase the risk of malnutrition. At the same time, there are additional risk factors to consider (Figure 2). Changes commonly associated with aging, such as loss of appetite, limited ability to chew or swallow, and use of multiple medications, can impact diet and nutrition.

Adults over the age of 60 have seen nearly a 60% increase in food insecurity from pre-COVID rates, meaning 13.5% of older adults now face food insecurity. [14]

Older adults are also at risk of malnutrition due to chronic illness, disease, injury, and hospitalization. Acute conditions, like those that require surgery, as well as chronic diseases such as cancer, diabetes, and gastrointestinal, lung, and heart diseases and their treatments, can result in changes in nutrient intake that can lead to malnutrition.

Further, with disease-associated malnutrition, inflammatory responses are increased, which can result in decreased appetite, gastrointestinal problems, diminished immune response, delayed wound healing, and increased infection rates. Such changes can increase risks for functional disability, frailty, and falling. Changes in functional ability can also lead to social isolation, which may cause depression and, in turn, affect cognitive functioning.

Changes in cognitive functioning for some older adults may also be risk factors for malnutrition.

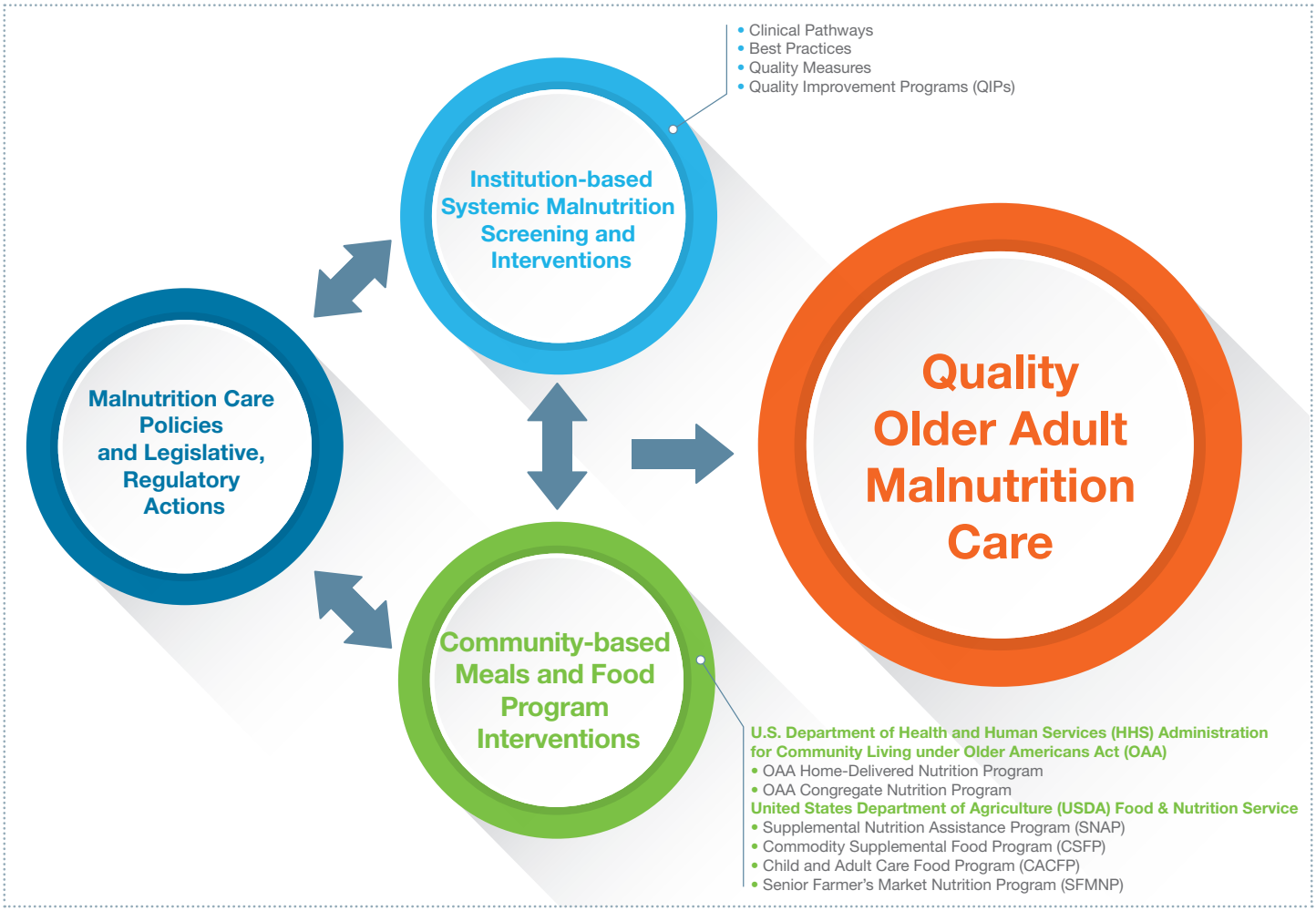
Many of the risk factors for older adult malnutrition are also risk factors for both contracting and developing more severe complications from acute respiratory viruses such as COVID-19.

Evidence shows the severity of COVID-19 infection is compounded by its interaction with nutrition, especially for the critically ill. More specifically, a higher prevalence of malnutrition (53% malnourished, 28% at risk of malnutrition) has been documented among older patients admitted to the hospital with COVID-19.[15] Most patients admitted to intensive care with COVID-19 were acutely malnourished,[16] and 45% of patients admitted to a rehabilitation unit following COVID-19 infection were at high risk for malnutrition.[17] Malnutrition's health impacts, particularly on respiratory and cardiac function, can likely affect the course of recovery of patients with COVID-19.[18] Nutrition status has been identified as an important factor influencing the outcome of COVID-19 patients.[19] COVID-19 is often accompanied by prolonged immobilization, which can increase risk for muscle wasting and protein loss.[17]

Figure 2: Contributing Factors that Lead to Malnutrition Among Older Adults[11]

Once malnutrition or risk for malnutrition is identified in older adults, there are important institution and community-based interventions that should be implemented. Both levels of intervention can be impacted by malnutrition care policies and legislative and regulatory actions (Figure 3). Additional information on community-based meals and food program interventions is provided in Appendix B.

Figure 3: Factors Influencing Quality Malnutrition Care for Older Adults



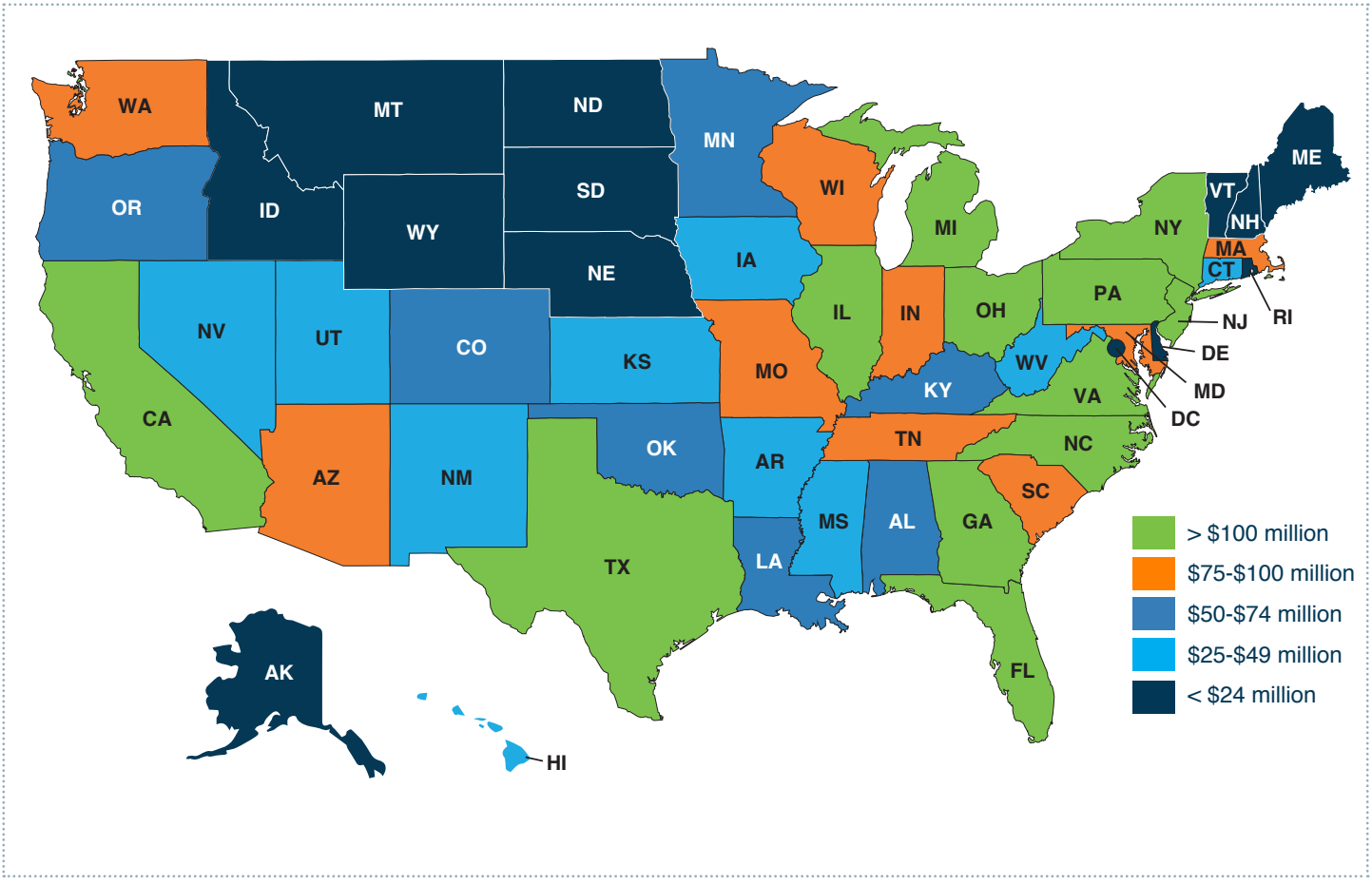
The Cost of Malnutrition

(Adapted from *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*)[11]

Malnourished older adults make more visits to physicians, hospitals, and emergency rooms[20] and are more likely to have increased rates of medical complications, including falls, delayed wound healing, increased infections, and increased hospital readmissions.[21-25]

Disease-associated malnutrition occurs when nutrient intake decreases and inflammatory responses increase.[26] A study examined and quantified state level economic burden (as measured in direct medical costs) of disease-associated malnutrition to "help policy makers more completely understand the magnitude of the problem and provide support for policy changes needed to better identify, prevent, and treat malnutrition."[27] The study also identified 12 states that have an annual economic burden of over $100 million for disease-associated malnutrition in older adults (Figure 4). Nationally, the cost of disease-associated malnutrition is estimated to be $53 billion per year.[1]

Figure 4: State Economic Burden of Disease-Associated Malnutrition in Older Adults[27]



Social Determinants of Health and Nutrition

Social determinants of health (SDOH) are the circumstances and the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH are so critical they have become one of the five overarching goals for Healthy People 2030. SDOH are separated into five distinctive domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context (Figure 5).

Figure 5: Social Determinants of Health[28]

Social determinants of health can greatly impact individual access to nutrition and quality of malnutrition care. If individuals live in safe, well-funded neighborhoods, they may have access to nutrition counseling and to a variety of places to get healthy affordable foods that are within walking distance or have public transportation to a nearby grocery store. Alternatively, they might live in neighborhoods that are not safe to walk or where the nearest health clinic or grocery store is 10 miles away and public transportation is unavailable. A new SDOH Congressional Caucus has been formed to highlight the opportunities for federal coordination to improve health outcomes and maximize existing and future federal investments. Information on the intersections of SDOH and nutrition and malnutrition care is detailed below.

Economic Stability

Healthy People 2030 goal: help people earn steady incomes that allow them to meet their health needs. Unfortunately, in the US today 1 in 10 people live in poverty[29]; they are less likely to be able to afford housing, transportation, health care, and healthy foods. These individuals frequently purchase inexpensive, unhealthy foods to stretch their food budgets which impacts their health outcomes and can fuel chronic disease risk including for obesity, diabetes, and high blood pressure. Communities of color are greatly impacted by poverty and risk for food insecurity. The COVID-19 pandemic has amplified these disparities causing more households overall to be food insecure but disproportionally impacting Black, Latino, Native

American, and households with children and older adults. Recently the term nutrition security has been introduced, referring to both the ability to access food and to access high quality food.

Education Access and Quality

Healthy People 2030 goal: increase educational opportunities and help children and adolescents do well in school. Often higher levels of education are associated with lower levels of poverty and greater access to resources. Higher education is associated with improved health outcomes and improved health outcomes are linked with better nutrition.[30] Education level affects disease risk, health behavior patterns, and diet quality. A developmental objective that is related to public health is to increase the inclusion of interprofessional preventive education in the curricula of health professionals.[31] One preventive education topic that is connected to a multitude of health outcomes is nutrition. Nutrition education can help reduce many chronic health conditions like obesity, diabetes, heart disease and hypertension. Nutrition is often not extensively taught in medical and nursing education. More nutrition education in the medical and nursing field could prompt more doctors and nurses to understand the importance of nutrition in preventive care and lead to more referrals to RDNs.

Health Care Access and Quality

Healthy People 2030 goal: increase access to comprehensive high-quality health care services. One in 10 people in the US are uninsured[32] but the rates are not distributed equally, with 26.7% of uninsured people being Latino, 15.2% Black, and 9% White.[33] Those who are uninsured frequently lack primary care access and consistent opportunities to be seen by a health care professional. This can limit their ability to be screened for conditions like malnutrition and food insecurity and subsequent referral to community-based resources. Older adults 65+ are covered by Medicare, but they may not have the resources to purchase additional coverage. The MNT Act of 2021 can help increase access to an RDN who can identify and treat malnutrition as well as provide care to help prevent or manage nutrition-related chronic diseases like prediabetes, obesity, or cardiovascular disease. Another aspect of health care access and quality is the ability to evaluate quality care and drive provider accountability. A new Global Malnutrition Composite Score[34] has been endorsed by the National Quality Forum and fully meets four specific health equity priorities that CMS has identified for reducing disparities in health. However, the measure has not been adopted by CMS even though adoption was strongly recommended in a bipartisan letter signed by 28 members of Congress.

Neighborhood and Built Environment

Healthy People 2030 goal: create neighborhoods and environments that promote health and safety.[35] Neighborhoods that support health and safety generally have access to more grocery stores and have fewer fast food restaurants. They have sidewalks where people can walk for exercise or to get food as well as safe, affordable public transportation. Limited access to grocery stores creates food deserts and increases risk for chronic health issues related to nutrition. Unfortunately, not all neighborhoods are created equally, and the previous practice of redlining and racial segregation still greatly impacts built environments and neighborhoods. Neighborhoods that were redlined are often marginalized, putting these populations at higher risk of poor nutrition. For example, communities of color are twice as likely to live near a fast food restaurant.[36]

Social and Community Context

Healthy People 2030 goal: increase social and community support. This goal includes the ability to talk with family and friends about health as well as health literacy and use of health technology. Talking to family and friends about health can increase knowledge on family risks for certain chronic diseases as well as provide an opportunity to better tailor family meals to support health. Increasing health literacy in all communities helps people understand their health and how it may be impacted by their nutrition and dietary habits.[37] Improved use of health technology may be linked to expansion of telehealth services and should include integration of malnutrition care.

A Blueprint for Success in Achieving Quality Malnutrition Care

To coalesce key stakeholders and focus attention on older adult malnutrition, the Defeat Malnutrition Today coalition and Avalere Health led the development, launch, and update of the *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*.[11]

The Blueprint outlines specific goals and strategies for the federal government. A selection of those goals and strategies are shown in Table 1.

Table 1: Recommendations for Federal Government to Improve Quality of Malnutrition Care for Older Adults[11]

Goal 1: Improve Quality of Malnutrition Care Practices	
Strategies	**Recommendations**
Establish Science- Based National Goals for Quality Malnutrition Care	• Recognize quality malnutrition care for older adults as a clinically relevant and cross-cutting priority in HHS's Quality Measure Development Plan, the Surgeon General's National Prevention Strategy and the HHS and U.S. Department of Agriculture's (USDA) Dietary Guidelines for Americans
Identify Quality Gaps in Malnutrition Care	• Recognize impact of malnutrition and quality gaps for older adults in national population health and chronic disease reports and action plans (e.g., malnutrition prevention, identification, and treatment needs in acute care, post-acute care, and home and community-based settings, and among priority disease-specific populations and during health pandemics)

Goal 2: Improve Access to High-Quality Malnutrition Care and Nutrition Services	
Strategies	**Recommendations**
Integrate Quality Malnutrition Care in Payment and Delivery Models and Quality Incentive Programs	• Adopt clinically relevant malnutrition quality measures in public and private accountability programs across the care continuum • Reduce barriers to transparency and transfer of clinically relevant malnutrition care data to downstream providers, individuals, and caregivers • Integrate quality malnutrition care in future chronic disease and surgical care demonstrations to develop innovative models to improve outcomes for malnourished and at-risk older adults • Engage relevant agencies or organizations (e.g., AHRQ, CMS, NQF) to support development of quality measures and payment mechanisms for malnutrition care that apply to providers and relevant professionals across all settings • Expand and incentivize Medicare Advantage coverage of home-delivered meals • Services offered should be comprehensive and not limited by specific medical conditions
Reduce Barriers to Quality Malnutrition Care	• Develop reports on access barriers to quality malnutrition care and nutrition services for older adults (e.g., gaps in public education, healthcare delivery systems, provider training and education, and resource allocation) • Advance national policies to allocate resources to support malnutrition screening of older adults at point of entry in post-acute care and community settings, as appropriate, and health departments • Adopt electronic data standards to assist in transfer of clinically relevant malnutrition and nutrition health information across care settings and telemedicine services (e.g., nutritional status, diet orders, other nutrition interventions) • Expand coverage of medical nutrition therapy services to apply beyond current limited list of conditions (i.e., end-stage renal disease [ESRD], chronic kidney disease [CKD], and diabetes) and the currently limited populations • Provide community providers with funds and data to support maintenance and continued growth of needed services

Goal 3: Generate Clinical Research on Malnutrition Quality of Care	
Strategies	**Recommendations**
Identify and Fill Research Gaps by Conducting and Disseminating Relevant Research	• Conduct national research on barriers and pathways to reduce barriers to malnutrition care and nutrition support • Engage the Office of Nutrition Research within the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to recommend nutrition research priorities • Conduct national research on barriers and pathways to reduce barriers to malnutrition care and nutrition support • Establish a central, publicly available location or source where stakeholders can access fundamental, evidence-based care standards for malnutrition care and integrate new evidence as it is developed. To help establish this resource, collaboration with organizations such as the ACL, AHRQ, or CMS could be explored. Focus on the specific nutritional needs of older adults in the 2025-2030 Dietary Guidelines for Americans, including focusing on information gaps on these specific needs, as identified by the 2019 GAO report • Explore partnerships to disseminate research with federal agencies (e.g., ACL and AHRQ)
Track Clinically Relevant Nutritional Health Data	• Establish electronic data standards to assist in transfer of clinically relevant nutrition health information across care settings (e.g., nutritional status, diet orders, other nutrition interventions) • Include clinically relevant malnutrition-related data in acute care, post-acute care, and community settings in national initiatives • Support public reporting of malnutrition quality-of-care data through national based reports

Goal 4: Advance Public Health Efforts to Improve Malnutrition Quality of Care	
Strategies	**Recommendations**
Educate and Raise Visibility with National Policymakers	• Seek to establish a third-party campaign (including through public-private partnerships) to educate the public and providers on what "optimal nutrition" is in order to understand malnutrition, causes of malnutrition (disease, acute illness, food insecurity), and the impact on health outcomes • Implement and build on recommendations of the GAO report, *Nutrition Assistance Programs: Agencies Could Do More to Help Address the Nutritional Needs of Older Adults*
Integrate Malnutrition Care Goals in National Population Health Management Strategies	• Engage clinicians, providers, and the Office of Disease Prevention and Health Promotion (ODPHP) to adopt malnutrition goals for older adults in Healthy People 2030 • Implement malnutrition screening standards for early identification with populations at high risk for malnutrition
Allocate Education and Financial Resources to HHS and USDA-Administered Food and Nutrition Programs	• Conduct research and publish report on share of resources required for various malnutrition prevention, malnutrition care, or food assistance programs • Distribute resources, as needed, based on findings from evaluated data or conducted research

Policy Opportunities to Address Older Adult Malnutrition

Malnutrition is pervasive, costly, and causes patients to feel worse and heal slower, but it has not yet been addressed by a systematic, consistent approach throughout the healthcare system.

Acute and post-acute care actions

Broadly, there is a general lack of awareness that malnutrition is linked to acute illness, chronic disease, and poor health outcomes. In addition, physicians and other clinicians receive limited nutrition training in medical schools and allied health programs. This should be tackled by including nutrition in medical education curricula requirements.

Many individuals among the public, including healthcare providers, are unaware of malnutrition's prevalence in older adults and are therefore limited in their ability to help identify and address the condition. As our nation moves to expand telehealth services, there is an opportunity to fully integrate malnutrition screening and care in telehealth programs and other provider access initiatives. While widespread expansion of telemedicine is positive, it could also further increase rather than reduce healthcare disparities, particularly for those older adults with sensory impairments, limited digital literacy and access to technology (including those in rural communities), lower incomes, and poor health literacy. There is also the potential for discrimination and mistrust to be magnified during virtual encounters, when patients may feel more limited in their ability to communicate and providers may be less mindful of guarding against implicit bias. Thus, as legislators explore providing broader access to telehealth, it will be important to consider adaptations based on urban/rural communities or other divides that limit access to the internet and reliable cell phone services, as well as develop solutions for increasing digital literacy.

In addition, care coordination of malnourished and at-risk older adults could be less fragmented if there were greater visibility among the clinical care team of relevant malnutrition data and documentation and standardization of key malnutrition data elements in electronic health records. Malnutrition care represents an important gap area that has been acknowledged by the CMS. However, malnutrition has not been included in our governmental public health objectives, nor is it reported in key health indicators for older adults or integrated into public or private quality incentive programs.

However, there has been initial movement; CMS approved including malnutrition quality measures in two Qualified Clinical Data Registries (QCDRs) for 2020 in the Merit-based Incentive Payment System (MIPS). Clinicians who are providing quality malnutrition care can report with the QCDR measures to help receive credit for quality care. Quality of care credit is a core determining factor for performance-based adjustments to Medicare reimbursement, which can impact overall provider financial viability. CMS also recently included malnutrition as part of a proposed achieving health equity improvement activity for MIPS.[38] Yet a required malnutrition care measure is still missing in acute and post-acute care settings.

Federal legislators can take action by including nutrition in medical education curricula requirements and by integrating malnutrion into public and private quality incentive programs

Community actions

At the community level, there are several areas where further action is needed. First, we must increase access to medical nutrition therapy (MNT), which is the nutritional diagnostic, therapy, and counseling services for disease management provided by an RDN who has been referred by a physician.[39] MNT has been shown to be a cost-effective component of treatment for a number of chronic diseases. The recently introduced Medical Nutrition Therapy Act of 2021 would add malnutrition to the list of chronic conditions that Medicare covers for MNT and also expand the types of clinicians who could make a referral for MNT (Appendix C).

Second, we must continue to increase funding for the federal nutrition programs to ensure they help meet the nutrition needs of older adults—including those newly-enrolled. There are several federal programs that provide food assistance and meals to older adults (Appendix D). COVID-19-related relief packages increased funding for Older Americans Act (OAA) meals programs; this funding should be extended, as these programs have had a surge in enrollments. The USDA's SNAP is the only means-tested nutrition program available to all eligible older adults in every part of the country. SNAP can reach all eligible older adults because of its funding structure; it is 100% federally funded. COVID-19 relief packages boosted the minimum and maximum SNAP benefits which helped many older adults. More recently, the Biden Administration has announced a permanent 25% increase in average SNAP benefits which may be a catalyst to get more older adults enrolled in SNAP. This increase needs to be paired with a strong nutrition education effort by USDA to help guide SNAP recipients in making nutrient-rich choices.

Third, we must build on and support the malnutrition components included in the OAA 2020 reauthorization. OAA programs include congregate and home-delivered meals. Reducing malnutrition is now part of the purpose of the OAA and malnutrition screening is included in the definition of OAA's disease prevention and health promotion services. Additional resource allocation could assist community OAA programs in operationalizing malnutrition screening.

A 2019 GAO report on nutrition assistance programs identified that federal agencies could do more to help address older adults' nutrition needs. It recommended that USDA and HHS could improve oversight of meal programs and provide additional information to meal providers to help them meet older adult nutritional needs.[40] There is also likely a need for increased outreach to older adults to help them learn more about the programs and opportunities for enrollment. Policymakers can play a role through funding older adult education and supporting more simplified enrollment policies.

Federal legislators can take action by supporting legislation to expand access to medical nutrition therapy (MNT), increase funding for federal nutrition programs, and operationalize Older Americans Act (OAA) malnutrition guidance

US Government Accountability Office recommendations for federal nutrition assistance programs[40]

Recommendation 1

The Administrator of ACL should work with other relevant HHS officials to document the department's plan to focus on the specific nutritional needs of older adults in the 2025-2030 update of the Dietary Guidelines for Americans, which would include, in part, plans to identify existing information gaps on older adults' specific nutritional needs.

Recommendation 2

The Administrator of ACL should direct regional offices to take steps to ensure states are monitoring providers to ensure meal consistency with federal nutrition requirements for meals served in the congregate and home-delivered meal programs.

Recommendation 3

The Administrator of FNS should take steps to improve its oversight of CACFP meals provided in adult day care centers. For example, FNS could amend its approach for determining federal onsite reviews of CACFP meal providers to more consistently include adult day care centers.

Recommendation 4

The Administrator of ACL should centralize information on promising approaches for making meal accommodations to meet the nutritional needs of older adult participants in the congregate and home-delivered meal programs, for example in one location on its National Resource Center on Nutrition and Aging website, to assist providers' efforts.

Recommendation 5

The Administrator of FNS should take steps to better disseminate existing information that could help state and local entities involved in providing CACFP meals meet the varying nutritional needs of older adult participants, as well as continue to identify additional promising practices or other information on meal accommodations to share with CACFP entities.

Public health actions

The GAO report also recommended that HHS document the department's plan to focus on the specific nutritional needs of older adults in the 2025-2030 update of the Dietary Guidelines for Americans (DGAs). The 2020-2025 DGAs for the first time included recommendations specific to older adults and identified malnutrition as a concern. However, more needs to be done, including expanding the research base on older adult nutrition requirements to better define the impact of malnutrition on health outcomes and health equity.

Finally, there is a need for better documentation of the prevalence of older adult malnutrition. There are examples of malnutrition screening tools, including a tool that identifies both risk for both malnutrition and food insecurity risk [Appendix E]. Unfortunately, across care settings--but particularly in the community—malnutrition is often not identified or documented. This makes it more difficult to determine variations across populations and to intervene when there may be a greater likelihood for success. Adding malnutrition screening and monitoring questions to national surveys of older adult health would help better document malnutrition as a public health problem and provide a basis for national health goals.[41]

Federal legislators can take action by supporting expansion of the research base on older adult nutrition to provide the basis for the 2025-2030 Dietary Guidelines for Americans (DGAs) and supporting inclusion of malnutrition screening in national surveys of older adults

A Quality Focus for Malnutrition Care

(Adapted from *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*)[11]

With the ever-increasing proportion of older adults in the US population, it is important to promote public health policies—like high-quality malnutrition care—that help keep older adults healthy and active. This begins by establishing malnutrition public health goals and quality measures that will evaluate the effectiveness of payment and healthcare systems in providing malnutrition care.

Currently, there are hundreds of quality measures and many that are required for quality incentive programs. However, until more recently, there have been no quality measures for malnutrition care, and there are still none for malnutrition care required in quality incentive programs.

Policies and actions to promote high-quality malnutrition care provide the impetus needed to implement basic practices that have yet to be embraced by the broader US healthcare system.

For example, in both acute care and post-acute care settings, simple shifts in institutional training to emphasize malnutrition screening and assessment are important first steps to potentially reduce the number of untreated cases of malnutrition. This can be strengthened with best practices and quality standards and measures for malnutrition adopted across the continuum of care, including through telehealth services.

Best practices, such as the Global Leadership Initiative on Malnutrition (GLIM) criteria for the diagnosis of malnutrition, the 2019 standards developed by the American College of Surgeons on geriatric surgery, or those specified for Enhanced Recovery After Surgery (ERAS)[42-44] techniques, include recommendations on malnutrition care. Further, advances are being made for older adult care in the acute care setting through the MQii—a collaboration of the Academy of Nutrition and Dietetics, Avalere Health, and other stakeholders.[45]

The MQii provides an innovative approach that recognizes the need to drive quality through the combined use of electronic clinical quality measures and an interdisciplinary toolkit to help hospitals achieve their performance goals for malnutrition care of older adults. In addition, there are over 300 hospitals (both public and private) across the country that are enrolled in an MQii Learning Collaborative and are using the toolkit and electronic clinical quality measures in order to raise awareness and build an infrastructure for ongoing quality measurement and improvement.

There is also a need to evaluate the effect of specific programs, such as home-delivered meal programs, on patient outcomes, particularly as there are now opportunities for Medicare Advantage plans to offer a home-delivered meal benefit to enrollees with chronic conditions.

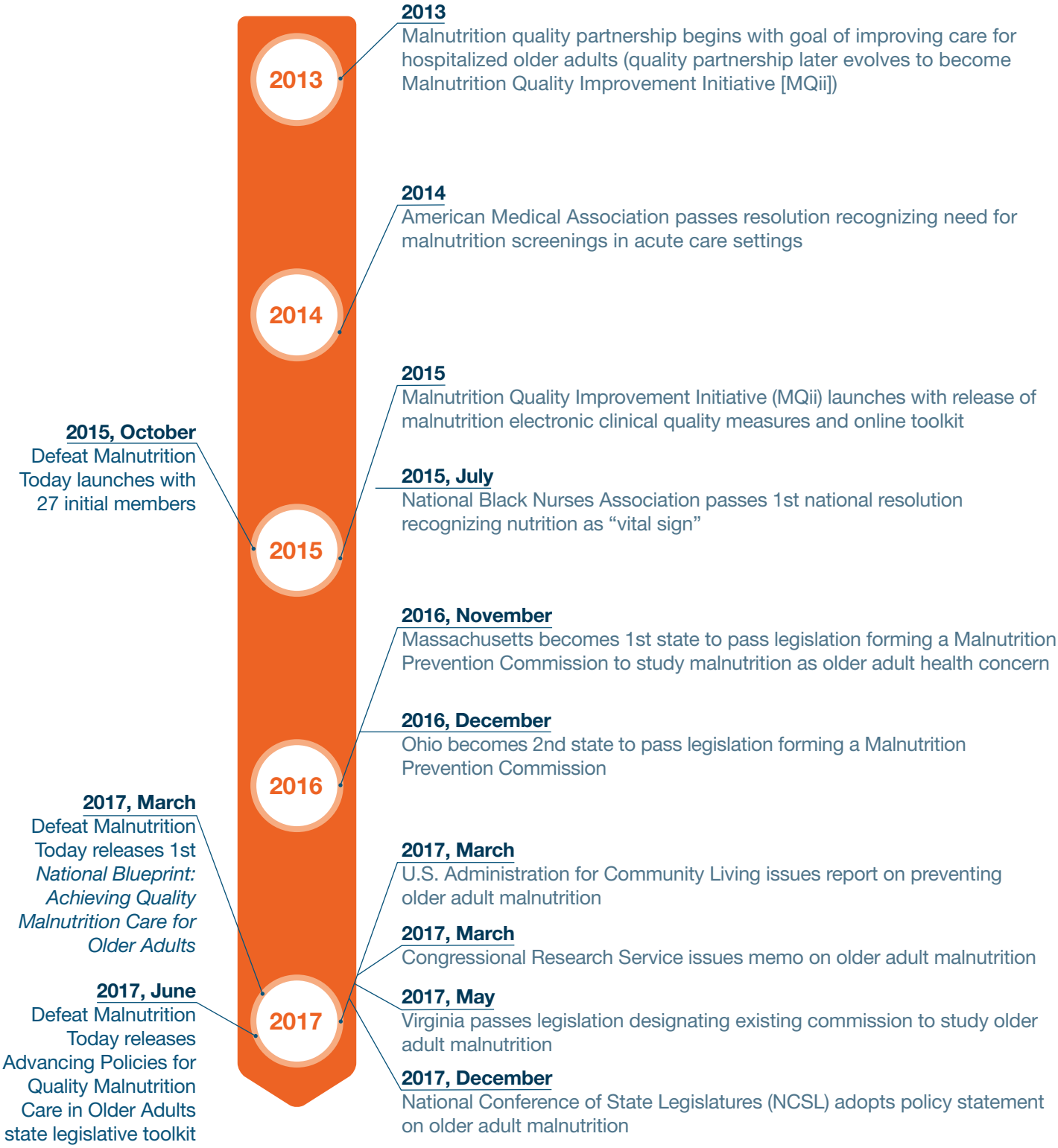
Conclusion and Call to Action /

The time to act is now! Up to one out of two older adults is either at risk of becoming malnourished or is malnourished.[7,8] It is estimated that disease-associated malnutrition costs the United States nearly $51.3 billion annually.[1] In a healthcare environment focused on health equity, healthy aging, patient-centeredness, and cost efficiency, systematic malnutrition screening and appropriate multidisciplinary intervention must become a mainstay of US healthcare. One way to help achieve this is through CMS adoption of malnutrition care quality measures in acute care and other care settings.

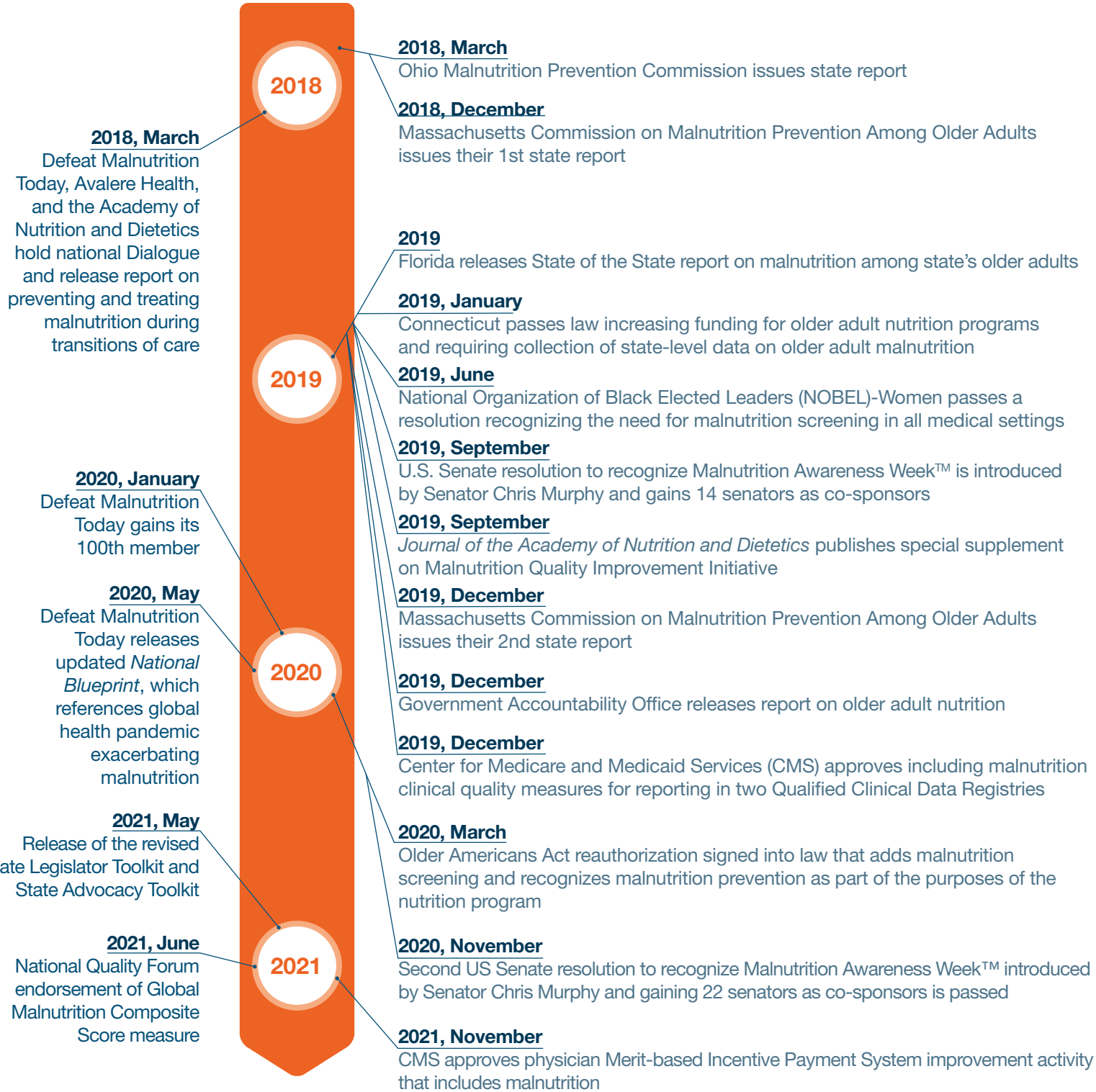
The COVID-19 pandemic and the rapidly growing older adult population have increased the urgency for policy and advocacy. The enactment of nutrition focused quality improvement programs, predominantly those targeting transitions of care may be valuable to help malnutrition risk screening become a part of routine medical care provided during pandemics. Prior to the COVID-19 pandemic, community-based programs were chronically underfunded and many had waiting lists for those seeking services. The significant surge in requests during the pandemic more than doubled the number of meals being provided which made an already strained financial situation even worse for these essential programs. The nutrition-related policies necessary for supporting older adults in the community during a pandemic are the same as those needed to help ensure healthy aging at any point in time, only magnified.

This updated toolkit outlines strategies and recommendations for policies to support a consistent, high-quality standard of malnutrition care in the United States. Multi-stakeholder collaborations and partnerships continue to be needed to bring these recommendations to life and to secure the future of healthy aging with good nutrition and high-quality, safe, coordinated malnutrition care. The value of quality malnutrition care must be realized, and our country's healthcare delivery, social services, and financial incentives must be aligned to address the epidemic of malnutrition in acute care, post-acute care, and community settings.

Appendix A: Malnutrition Policy Through the Decade

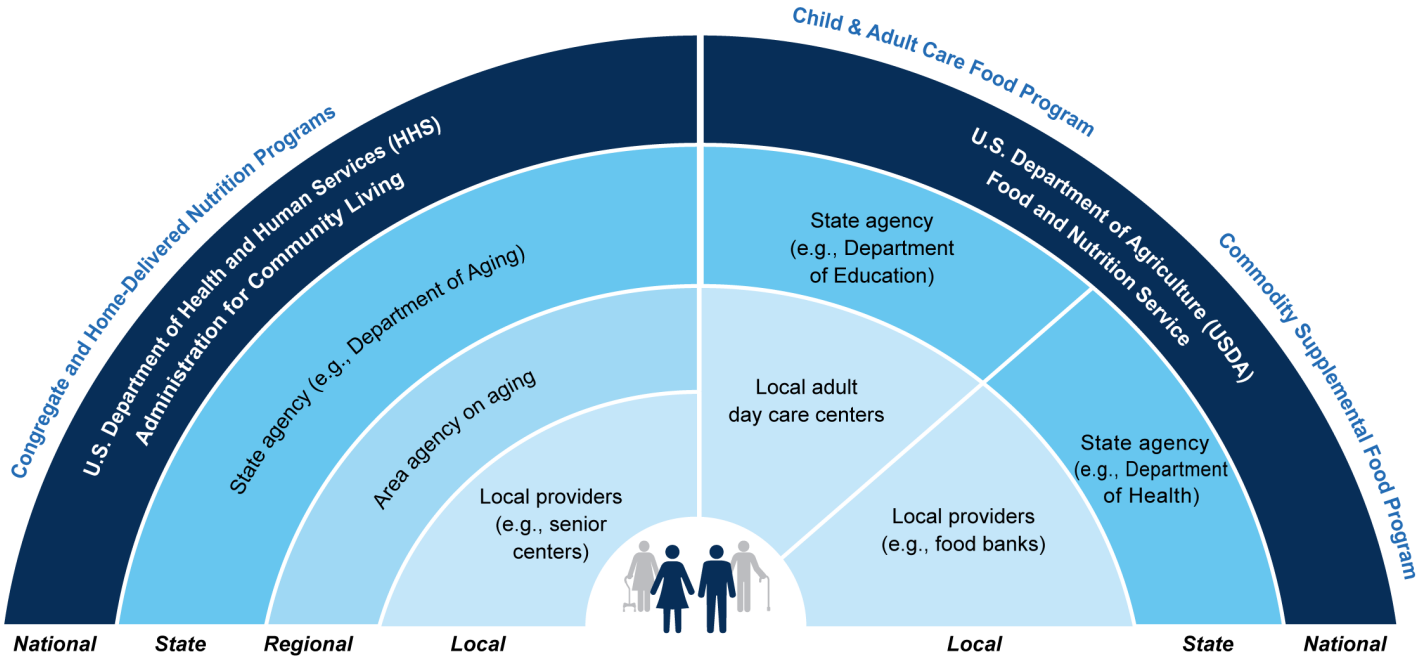


Appendix A: Malnutrition Policy Through the Decade (cont.)



Appendix B: Stakeholders and Resources for Older Adult Meals and Food Assistance

Stakeholders Involved in Administering Selected Nutrition Assistance Programs That Directly Provide Meals and Food to Older Adults[40]



Source: GAO analysis of HHS and USDA program information and interviews with HHS and USDA officials. | GAO-20-18[38]

Resource Links for Meals and Food Assistance Programs for Older Adults

Meals on Wheels Program Locator: http://bit.ly/find-HDM

Food Bank Locator: http://bit.ly/find-foodbank

SNAP Information: http://bit.ly/SNAP-apps

The Emergency Food Assistance Program (TEFAP) Link to Local State Agency Contact Information: http://bit.ly/TEFAP-contacts

Appendix C: Medical Nutrition Therapy Act of 2021

This summary was developed by the Academy of Nutrition and Dietitians[46]

LEAVE BEHIND FOR MEMBERS OF CONGRESS

Medical Nutrition Therapy Act

(H.R.3108 / S.1536)

eat right. Academy of Nutrition and Dietetics

About Us

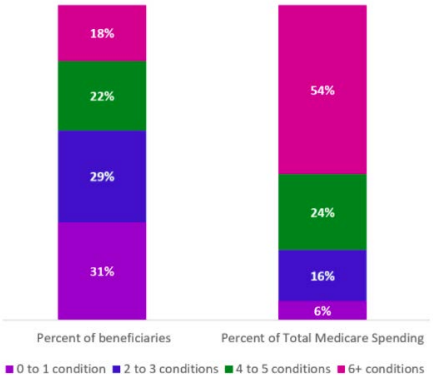
Representing more than 112,000 credentialed nutrition and dietetics practitioners, the **Academy of Nutrition and Dietetics** is the world's largest organization of food and nutrition professionals. Many Academy members - registered dietitian nutritionists, nutrition and dietetic technicians, registered, and advanced-degree nutritionists - treat the Medicare population.

The Cost of Chronic Conditions

According to the CDC, 90% of the nation's $3.5 trillion annual health care expenditures is spent on treating chronic and mental health conditions.[1,2] Care for individuals with multiple chronic conditions is especially costly in the Medicare population (see figure).[3]

Many diet-related chronic conditions are contributing to poor COVID-19 outcomes. Minority populations have long faced chronic disease health disparities due to socioeconomic inequalities and reduced access to health care, healthy foods and safe places to be active. It is these same groups that are now disproportionately impacted by COVID-19. The compounding impacts of systemic inequalities, food insecurity, reduced access to care and now COVID-19, underscore the need to provide equitable access to medical nutrition therapy in Medicare.

Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Spending, 2018[3]



Barriers to Care for Seniors

Currently, Medicare Part B only covers outpatient MNT for diabetes, renal disease and post-kidney transplant.[4] Additionally, qualified providers such as nurse practitioners, physician's assistants, clinical nurse specialists and psychologists are barred from directly referring their patients to MNT services.

MNT is an Effective Solution

MNT has been shown to be a cost-effective component of treatment for obesity, diabetes, hypertension, dyslipidemia, HIV infection, unintended weight loss in older adults and other chronic conditions.[5-8] Counseling provided by an RDN as part of a health care team can positively impact weight, blood pressure, blood lipids and blood sugar control.[9,10] In a national survey of primary care physicians, respondents reported believing that RDNs were the most qualified health care providers to assist patients with weight loss.[11] Additionally, the National Lipid Association recommends nutritional counseling by RDNs to promote long-term adherence to an individualized, heart- healthy diet.[12]

What is an RDN?

Registered Dietitian Nutritionists are credentialed nutrition practitioners who have completed:

- An accredited bachelor's degree (or higher) in dietetics
- 1,200+ hours of supervised practice
- The national Registration Examination for Dietitians

To maintain the credential, RDNs must also secure 75+ hours of continuing education every five years.

What is MNT?

Medical Nutrition Therapy is an evidence-based application of the Nutrition Care Process that can include nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation.

The goal of MNT is to prevent, delay or manage disease and conditions.

October 2021

Appendix C: Medical Nutrition Therapy Act of 2021 (cont.)

This summary was developed by the Academy of Nutrition and Dietitians[46]

What the MNT Act Does

This bill amends the Social Security Act to provide Medicare Part B coverage of outpatient MNT for **prediabetes, obesity, high blood pressure, high cholesterol, malnutrition, eating disorders, cancer, gastrointestinal disease including celiac disease, cardiovascular disease, HIV/AIDS** and any other disease or condition causing unintentional weight loss, with authority granted to the Secretary of Health to include other diseases based on medical necessity. It also authorizes nurse practitioners, physician assistants, clinical nurse specialists and psychologists to **refer their patients for MNT**.

Co-sponsor the MNT Act

The Academy of Nutrition and Dietetics urges members of Congress to co-sponsor and support passage of the Medical Nutrition Therapy Act. The bill was introduced in the 117th U.S. Congress by U.S. Sens. Susan Collins (Maine) and Gary Peters (Mich.) and U.S. Reps. Robin Kelly (Ill.) and Fred Upton (Mich.).

To become a co-sponsor, please contact:
Sen. Collins' office: Maria Olson (Maria_Olson@aging.senate.gov)
Sen. Peters' office: Darian Burrell-Clay (Darian_Burrell-Clay@peters.senate.gov)
Rep. Kelly's office: Anita Burgos (Anita.Burgos@mail.house.gov)
Rep. Upton's office: Mark Ratner (Mark.Ratner@mail.house.gov)

For more information from the Academy of Nutrition and Dietetics, please contact:
Hannah Martin, MPH, RDN, Director, Legislative and Government Affairs (hmartin@eatright.org)

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October 2021

Appendix D: Federal Nutrition Assistance Programs Serving Older Adults and Opportunities for Federal Legislators

Program	Eligible population	Type of assistance	No. of older adult participants in 2017	Total federal appropriations in FY 2021*	Opportunities for federal legislators
HHS Administration for Community Living					
Home-Delivered Nutrition Program	Adults 60 years or older	Prepared meals delivered to participants who are usually homebound	850,880	$276 million	This program relies on federal, state, and local funding and will benefit from increased funding to support expanded enrollments
Congregate Nutrition Program	Adults 60 years or older	Prepared meals provided in congregate settings, such as senior centers	1,520,507	$515 million	This program relies on federal, state, and local funding and will benefit from increased funding to re-open programs
USDA Food and Nutrition Service					
Supplemental Nutrition Assistance Program (SNAP)	Households, including those with older adults with low income	Benefits to purchase food in participating retail stores	5,447,000	$114 billion	SNAP is a fully funded federal program, and older adults will benefit from policies streamlining enrollment as well as awareness campaigns promoting enrollment
Commodity Supplemental Food Program (CSFP)	Adults 60 years or older with low income	A monthly supplemental package of shelf-stable foods and refrigerated cheese	675,926	$325 million	This federal program may not be well-known, and older adults will benefit from promotion of information about this program. The program would also benefit from additional funding
Child and Adult Care Food Program (CACFP)	Adults who are physically or mentally impaired or adults 60 years or older enrolled in an adult day care program	Prepared meals provided in nonresidential adult day care centers	134,694	$4.3 billion	CACFP is not a fully funded federal program and will benefit from legislation supporting additional funding
Senior Farmers' Market Nutrition Program (SFMNP)	Adults who are 60 years or older with low income	Benefits to purchase locally grown fruits, vegetables, honey, and herbs from farmers' markets, roadside stands, and community programs	834,875	$21 million	SFMNP is not a fully funded federal program and will benefit from legislation supporting additional funding

* Additional appropriations during the COVID-19 pandemic as of January 2021 include $1.675 billion total for home-delivered and congregate nutrition programs and $19.6 billion for the Supplemental Nutrition Assistance Program.

Appendix E: Sample Malnutrition and Food Insecurity Screening Tool

This sample tool was developed and tested by the Ohio Malnutrition Working Group and can be adapted for use in other states.

Older Adult Malnutrition and Food Insecurity Screening

The Ohio Department of Health (ODH) recently convened a multi-stakeholder statewide commission to look at malnutrition in Ohio, and issued a report with policy recommendations and local strategies to address malnutrition (https://docs.wixstatic.com/ugd/c577a8_48c4ffc3726b4f64939760bb76f0c35b.pdf).

Partners in Central Ohio felt that the time had come to develop a common, regional plan to address senior malnutrition and ways to implement the ODH Commission Report's policy recommendations. The first result of this work is the following tool that all providers—physicians (independent practices and hospitalists/specialists), nurses, social service agencies, care coordinators, and registered dietitians—can utilize to quickly identify BOTH malnutrition AND food insecurity risk with their older adult patients/clients, as well as provide direction and resources regarding next steps based on the results.

MALNUTRITION SCREENING TOOL[1]		
1. Have you recently lost weight without trying?		
No	0	
Not Sure	2	
Yes *If yes, how much weight have you lost?* 2-13 lbs	1	
14-23 lbs	2	
24-33 lbs	3	
34 or more lbs	4	
Unsure	2	**Question 1 Score:**
2. Have you been eating poorly because of decreased appetite?		
No	0	
Yes	1	**Question 2 Score:**
		Total Score:

Results

Questions 1 & 2 Total	
Score of 0-1	Patient is not at risk for malnutrition; screen again in 1 year or if condition changes.
Score of 2 or more	Patient is at risk for malnutrition and needs a referral to registered dietitian and/or a healthcare provider and ongoing monitoring.

[1] Ferguson M, et al. Nutrition. 1999;15(6):458-464.

Resources

- Find a Registered Dietitian Nutritionist (RDN)
- **Congregate Meals:** served in group settings, provide nutritious meals and opportunities for social interactions
- **Home Delivered Meals:** often referred to as "meals on wheels," provides nutritious meals delivered to the door of older adults with limited mobility, who are homebound, or have a lack of transportation

Helpful Conversation Starters:

- Malnutrition can be caused by not getting enough of the nutrients your body needs to stay healthy or recover. You can be underweight or overweight and be malnourished. Have you ever been screened for malnutrition before?
- Have there been any changes in your health or life that may have caused weight loss?

For more information, visit the Ohio Department on Aging.

Appendix E: Sample Malnutrition and Food Insecurity Screening Tool (cont.)

FOOD INSECURITY SCREENING TOOL[1, 2]	
1. Within the last 12 months, I worried whether my food would run out before I had money to buy more.	
Often True	
Sometimes True	
Never True	
2. Within the last 12 months, the food I bought just didn't last and I didn't have money to get more.	
Often True	
Sometimes True	
Never True	

Results

Questions 1 & 2 Responses	
***Never true* for both questions**	Patient is not food insecure; screen again in 1 year or if living conditions change.
***Often true/sometimes true* for one or both questions**	Patient should be referred to meal services (see resources section) and/or a foodbank/food pantry; continue to monitor.

Resources

- **Congregate Meals:** served in group settings, provide nutritious meals and opportunities for social interactions
- **Home Delivered Meals:** often referred to as "meals on wheels," provides nutritious meals delivered to the door of older adults with limited mobility, who are homebound, or have a lack of transportation
- **Senior Farmer's Market Nutrition Program:** provides coupons for older residents that can be redeemed for fresh feeds from farmers' markets and roadside stands (available in select counties)
- **Commodity Supplemental Food Program:** supplements the diets of older adults with nutritious foods
- **Supplemental Nutrition Assistance Program (SNAP):** provides nutrition benefits to supplement the food budget of those in need

Helpful Conversation Starters:

- Just like your medication is important to keep you healthy, food is medicine too. Have you ever learned about the importance of getting enough nutritious food before?
- Who typically does the shopping for food in your home?
- I noticed you are having trouble getting enough healthy foods. Are you aware of the options available to you to access food or resources to buy food?

For more information,
visit the Ohio Department on Aging.

[1] Hager ER, et al. Pediatrics. 2010;126(1): e26-e32.
[2] Gundersen C, et al. Public Health Nutr. 2017;20(8):1367-71.

Appendix F: Glossary of Terms

Acute Care: refers to treatment for a patient that is usually brief but for a severe episode of illness or conditions that result from disease or trauma. Hospitals are generally the setting where acute care is provided and include community, rural, and critical access hospitals

Community-Based Services and Supports: The blend of health and social services provided to an individual, caregiver, or family member for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability. These person-centered services are usually designed to maximize an older person's independence at home or participation in the community. Such services and supports can include senior centers, transportation, home-delivered meals or congregate meal sites, visiting nurses or home health aides, adult day health services, and homemaker services

Food insecurity[47]: a household-level economic and social condition of limited or uncertain access to adequate food. Ranges of food insecurity as defined by the USDA are as follows:

- Low food security: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake
- Very low food security: reports of multiple indications of disrupted eating patterns and reduced food intake

Food security[47]: access at all times to enough food for an active, healthy life for all household members. Ranges of food security as defined by the USDA are as follows:

- High food security: no reported indications of food-access problems or limitations
- Marginal food security: one or two reported indications—typically of anxiety over food sufficiency or shortage of food in the house. Little or no indication of changes in diet or food intake

Hunger[47]: "an individual-level physiological condition that may result from food insecurity." More generally, it is a sensation resulting from lack of food or nutrients, characterized by a dull or acute pain in the lower chest. Hunger is distinguished from appetite in that hunger is the physical drive to eat, while appetite is the psychological drive to eat, affected by habits, culture, and other factors

Malnutrition[6]: a state of deficit, excess, or imbalance in energy, protein, or nutrients that adversely impacts an individual's own body form, function, and clinical outcomes

Malnutrition screening[48]: the systematic process of identifying an individual with poor dietary or nutrition characteristics who is at risk for malnutrition and requires follow-up assessment or intervention

Medical nutrition therapy[39]: nutritional diagnostic therapy and counseling services provided by a dietitian or nutritional professional for the purpose of managing disease following a referral by a physician

Merit-based Incentive Payment System (MIPS)[49]: a CMS quality payment program that determines Medicare payment adjustments. Under MIPS, clinicians are included if they are eligible clinician types and have low volume threshold, which is based on allowed charges for covered professional services under the Medicare Physician Fee Schedule and the number of Medicare Part B patients who are furnished covered professional services under the Medicare Physician Fee Schedule

Older adult: adult 65 years or older, eligible to receive Medicare

Qualified Clinical Data Registry (QCDR)[50]: a CMS-approved vendor that collects clinical data from practitioners and reports this data to CMS on their behalf for payment model requirements as well as quality reporting purposes. QCDR organizations can include specialty societies, regional health collaboratives, large health systems, or software vendors that collaborate with one of these medical entities

Quality improvement[51]: systematic activities that are organized and implemented by an organization to monitor, assess, and improve its healthcare with the goal of seeking continuous improvement in the care delivered to the patients the organization serves

Appendix F: Glossary of Terms (cont.) /

Quality measures[52]: tools that help measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality healthcare and/or that relate to one or more quality goals for healthcare

Social determinants of health[28]: the environmental conditions in which individuals are born, live, learn, work, and age that affect their health, functioning, and quality-of-life outcomes and risks. Resources that enhance quality of life, including access to good nutrition and availability of healthy foods, can have a significant influence on population health outcomes

Resources

Studies/Papers

- Addressing Disease-Related Malnutrition in Hospitalized Patients: A Call for a National Goal (2015)
http://bit.ly/2015-DAMpaper

- Aging Policy: Preventing, Treating Malnutrition to Improve Health and Reduce Costs (2014)
http://bit.ly/GSA-malnutrition

- Call for Action for Malnutrition Policy (2019)
http://bit.ly/JAND-calltoaction-2019

- Economic Burden of Community-Based Disease-Associated Malnutrition in the United States (2014)
http://bit.ly/DAM-2014

- Economic Burden of Disease-Associated Malnutrition at the State Level (2016)
http://bit.ly/DAM-state

- Government Accountability Office Report on Nutrition Assistance Programs http://bit.ly/GAO-report

- Journal of the Academy of Nutrition and Dietetics Supplement: Malnutrition Quality Improvement Initiative Yields Value for Interdisciplinary Patient Care and Clinical Nutrition Practice (2019)
http://bit.ly/JAND-mal-supp

- Malnutrition Vigilance During Care Transitions (2015)
http://bit.ly/mal-2015

Organizational Resolutions

- National Black Nurses Association Resolution http://bit.ly/NBNA-res

- National Lieutenant Governors Association Resolution http://bit.ly/NLGA-res

- National Organization of Black Elected Leaders (NOBEL)-Women Resolution http://bit.ly/NOBEL-W-res

Toolkits and Other Resources

- Alliance for Aging Research Malnutrition Tools
  - film: Food for Thought: The Role of Nutrition in Healthy Aging: https://www.youtube.com/watch?v=fcXxI_htZS0
  - film in Spanish: https://www.youtube.com/watch?v=GGZmwN0kEqU
  - Malnutrition: A Hidden Epidemic in Older Adults: https://www.youtube.com/watch?v=iPNZKyXqN1U
  - film in Spanish: https://www.youtube.com/watch?v=ADfqv42L7KI
  - resources: http://www.agingresearch.org/malnutrition
  - press release: https://www.agingresearch.org/press-release/press-kit-for-malnutrition-a-hidden-epidemic-in-older-adults/
- ASPEN Malnutrition Toolkit http://bit.ly/ASPEN-mal
- Congressional Research Service Memo on Malnutrition in Older Adults: http://bit.ly/CRS-mal-memo

Resources (cont.)

- Food Is Medicine Advocacy Toolkit
http://bit.ly/FIMC-advocacy

- Letter to CMS from House Members on Quality Measure
https://www.defeatmalnutrition.today/sites/default/files/Letter%20to%20Administrator%20Chiquita%20Brooks-LaSure.pdf

- Malnutrition Policy Fact Sheet
http://bit.ly/mal-policy-sheet

- Malnutrition Quality Improvement Initiative (MQii) Toolkit
http://bit.ly/MQii-toolkit

- National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update
http://bit.ly/malblueprint-2020

- National Blueprint 2020 infographic
http://bit.ly/malinfog-2020

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