Advancing Policies for Quality Malnutrition Care in Older Adults:

A Toolkit for State 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 State Legislator:

As you are working to support your constituency, balance budgets, and advocate for comprehensive state healthcare strategies, taking policy actions on nutrition is an important area to consider. Nutrition is an issue that impacts all constituents 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.

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. 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.

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 are isolating themselves, which may limit their access to food, particularly healthy food. Many seniors 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 insecure. This translated into 5.3 million and 2.0 million seniors facing food insecurity or very low food insecurity.[2]

COVID-19 has significantly changed the economic landscape, and unemployment rates are rising. Feeding America predicts that if the unemployment rate increases to 7.6%, food insecurity may increase by 5.2%.[3] Such growth in food insecurity nationwide will likely increase rates of food insecurity among seniors too, as many often continue to work beyond age 65, and thus older adult malnutrition rates may grow as well.

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.

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Top-line Summary /

Malnutrition is an imbalance in energy, protein, or nutrients that adversely impacts an individual's own body form, function, and clinical outcomes.[4]

Older adult malnutrition is a growing crisis

- Up to one out of two older adults is either at risk of becoming or is malnourished[5,6]
- Disease-associated malnutrition in older adults is estimated to cost $51.3 billion annually[1]

Malnutrition is a patient safety risk and can impact healthy aging and health outcomes

- Yet malnutrition is often not identified or treated
- According to the Academy of Nutrition and Dietetics[7]:
  - 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 care is recognized as an important gap area[8]

- However, there are no state public health goals on malnutrition, and malnutrition quality measures are not included in quality incentive programs
- 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 address the issue of malnutrition[8]
- COVID-19 has revealed the importance of telehealth as an opportunity to stay connected to patients. Telehealth connects registered dietitian nutritionists with patients who may be at risk for malnutrition or are already malnourished

State legislators can take action

Malnutrition policy actions are needed now!

- Proactive legislative and public health policy actions can help ensure quality malnutrition care is included in preventive and social services, patient safety, care transitions, and population health strategies for older adults
- Policy actions can include establishment of a Malnutrition Prevention Commission for Older Adults, recognition of Malnutrition Awareness Week™[9] through a resolution, and the inclusion of strategies related to malnutrition care in state healthcare quality improvement initiatives
- Other policy actions particularly important during the COVID-19 pandemic but also critical for long-term solutions to older adult malnutrition include supporting legislation to increase funding for congregate and home-delivered meals; providing information and encouragement to constituents to sign up for food assistance programs; advocating for state waivers to simplify enrollment in the federal Supplemental Nutrition Assistance Program (SNAP). Refer to Appendix A to see what federal nutrition plans are affected by changes at the state level

Quality Malnutrition Care as a Public Health Issue /

(Adapted from National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update)[8]

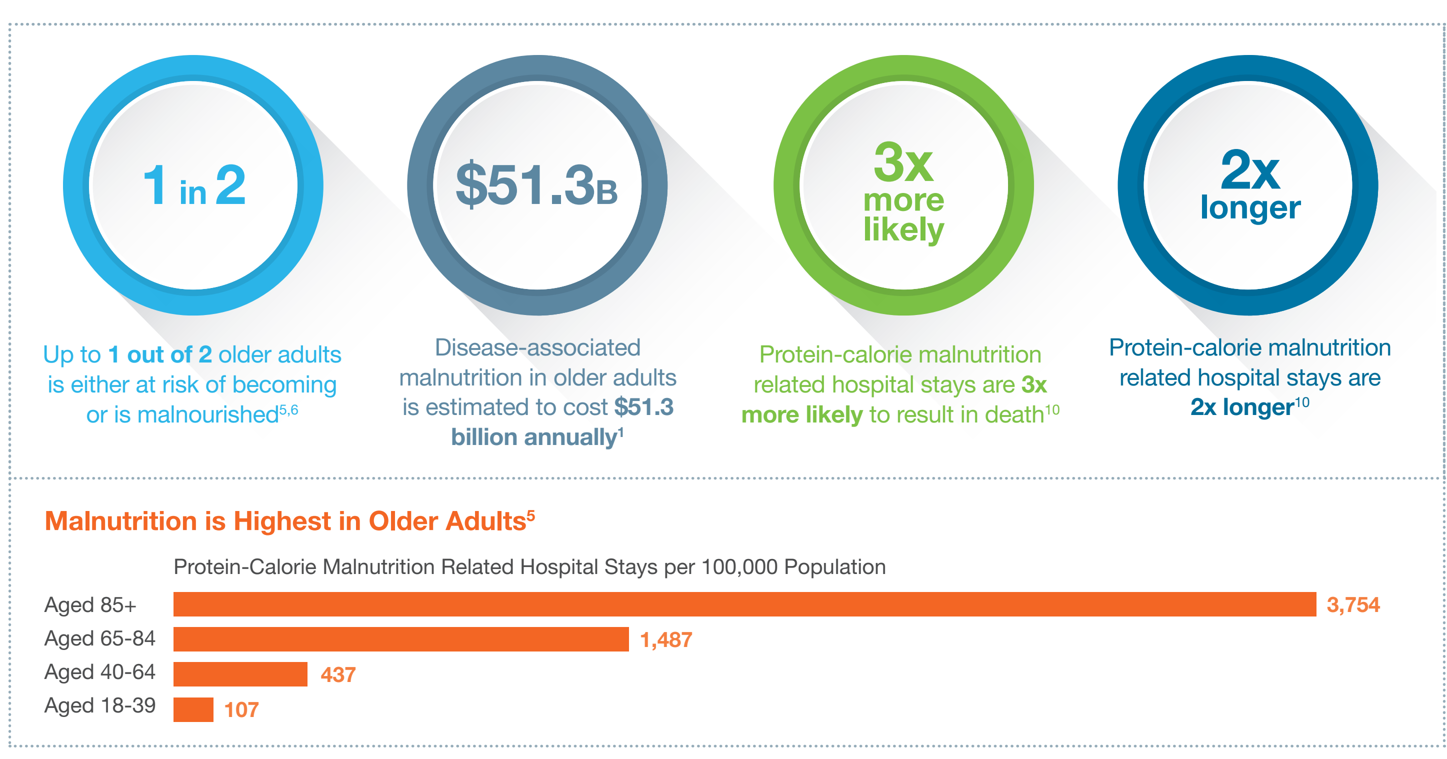
High-quality nutrition and malnutrition care for older adults should be at the top of the state agendas as we develop population health strategies to improve health and to deliver consistent quality healthcare at an affordable cost and tackle social determinants of health.

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. 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 State Legislators.

Figure 1: Malnutrition is a Critical Public and Patient Safety Issue *(national data)*



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.

Pandemic health measures, such as stay-at-home orders, can cause social isolation and limit access to food.

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.

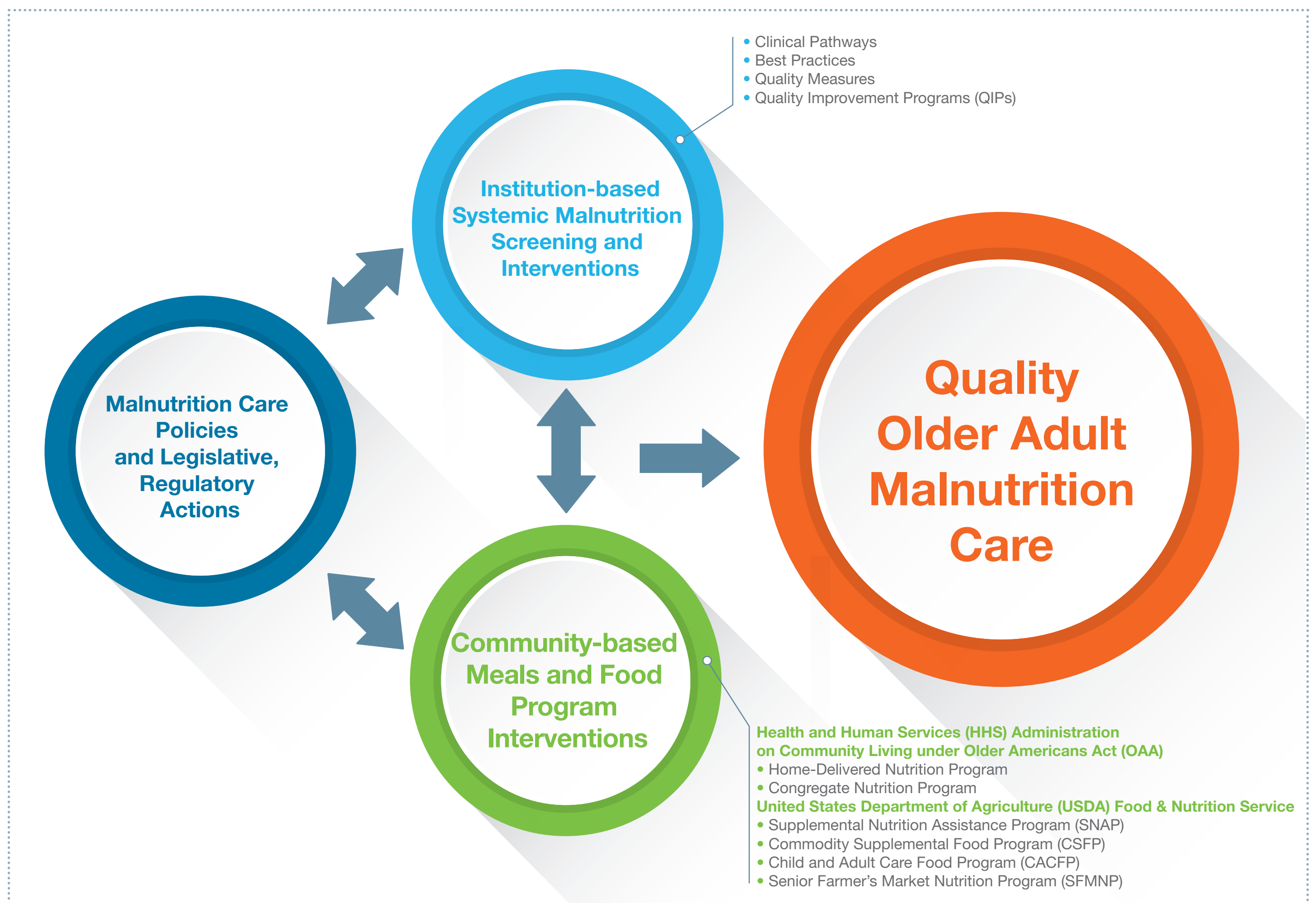
Many of the risk factors for older adult malnutrition are also risk factors for both contracting and developing more severe complications from acute respiratory viruses such as COVID-19.

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.[10] Most patients admitted to intensive care with COVID-19 were acutely malnourished,[11] and 45% of patients admitted to a rehabilitation unit following COVID-19 infection were at high risk for malnutrition.[12] Malnutrition's health impacts, particularly on respiratory and cardiac function, can likely affect the course of recovery of patients with COVID-19.[13] Nutrition status has been identified as an important factor influencing the outcome of COVID-19 patients.[14] COVID-19 is often accompanied by prolonged immobilization, which can increase risk for muscle wasting and protein loss.[12]

Figure 2: Contributing Factors that Lead to Malnutrition Among Older Adults[8]

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



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

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. 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 integrate malnutrition screening 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 states 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 Centers for Medicare & Medicaid Services (CMS). Yet, malnutrition has not been included in our governmental health objectives, nor is it reported in key health indicators for older adults or integrated into public or private quality incentive programs.

State legislators can take action by including malnutrition in state health objectives and by urging the federal government to follow the lead of states.

However, there has been initial movement, as CMS approved including malnutrition quality measures in two Qualified Clinical Data Registries (QCDRs) for 2020 in the Merit-based Incentive Payment System (MIPS). Approval for the malnutrition quality measures in the MIPS may lead to states getting more funds for malnutrition care. The malnutrition quality measures are included in the Premier Clinician Performance Registry and the US Wound Registry to help promote team collaboration with measures for outpatient physicians and dietitians reporting (Appendix C). Thus, clinicians who are providing quality malnutrition care will be able to report with these 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. The 2020 reauthorization of the Older Americans Act also called for malnutrition screening for participants in senior nutrition programs, such as Meals on Wheels and congregate meals.

The time to act is now! In a healthcare environment focused on healthy aging, preventive care, patient-centeredness, and cost efficiency, systematic malnutrition screening and appropriate multidisciplinary intervention must become a mainstay of US healthcare. The COVID-19 health pandemic has underscored that poor nutrition may be a relevant factor influencing the health outcomes of older adults. 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.

The Cost of Malnutrition /

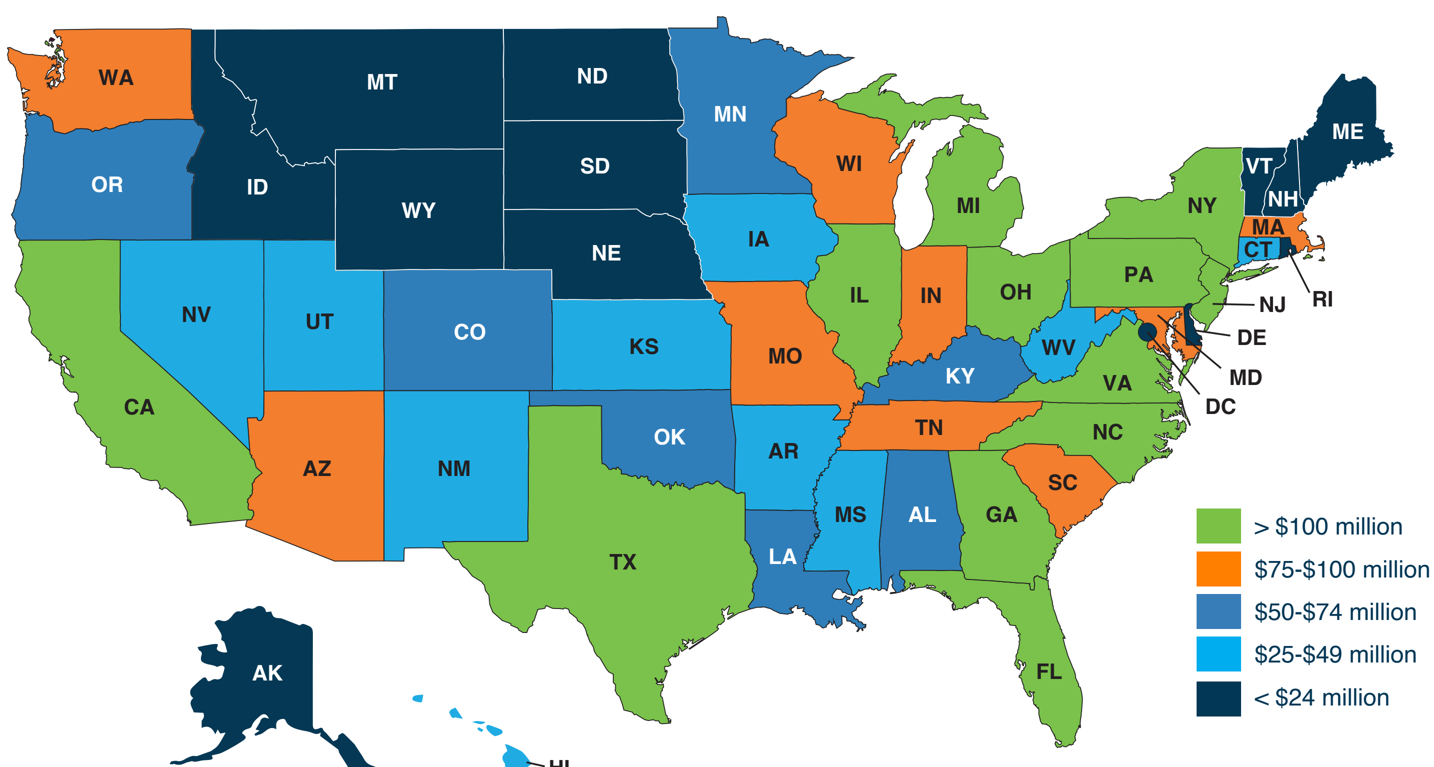
(Adapted from National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update)[8]

Malnourished older adults make more visits to physicians, hospitals, and emergency rooms[15] and are more likely to have increased rates of medical complications, including falls, delayed wound healing, increased infections, and increased hospital readmissions.[16-20]

Disease-associated malnutrition occurs when nutrient intake decreases and inflammatory responses increase.[21] 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."[22] The results of this study identified 12 states that have an annual economic burden of over $100 million for disease-associated malnutrition in older adults (Figure 4).

Further details on the annual economic burden of older adult malnutrition by state are provided in Appendix D.

Figure 4: State Economic Burden of Disease-Associated Malnutrition in Older Adults[22]



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.*[8]

The *Blueprint* outlines specific goals and strategies for state governments. A selection of those goals and strategies are shown in Table 1, along with comments for state legislators to use in promoting and achieving high-quality malnutrition care across the continuum of acute, post-acute, and community settings.

Table 1: Recommendations for State Governments to Improve Quality of Malnutrition Care for Older Adults

Goal 1: Improve Quality of Malnutrition Care Practices		
Strategies[8]	**Recommendations[8]**	**Comments for State Legislators**
Identify Quality Gaps in Malnutrition Care	• Recognize impact of malnutrition and quality gaps for older adults in state and local population health and chronic disease reports and action plans (eg, 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)	• Data collection should also target identifying possible gaps that may be influenced by age, race, ethnicity, language ability, and residence in an urban or rural setting. This will help further identify where the greatest needs are in a state. Coordination between state and local health officials is key

Goal 2: Improve Access to High-Quality Malnutrition Care and Nutrition Services		
Strategies[8]	**Recommendations[8]**	**Comments for State Legislators**
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	• The malnutrition electronic clinical quality measures developed by the Malnutrition Quality Improvement Initiative (MQii) could serve as a resource
Reduce Barriers to Quality Malnutrition Care	• Advance state 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 • Appoint state-level lead agencies to disseminate policy standards that require addressing malnutrition across all state department programs and services • Resolve state regulatory barriers to advance dietitian order writing privileges for clinical/nutrition orders that are permitted by federal regulation	• Malnutrition screening could be incorporated into other healthcare screenings and wellness checks • State Departments of Aging and other social-service agencies can help fill this role • Centers for Medicare and Medicaid Services (CMS) has authorized the participation of dietitians in the issuance of therapeutic diet orders in hospitals and long-term care (LTC) facilities if consistent with state laws and facility policy. In most states, hospitals and LTC facilities are governed by different regulations and implementation of order writing privileges may differ depending on the care setting. Lack of dietitian order writing privileges does not impact a state's ability to access federal funding but does potentially limit patient access to quality malnutrition care. Additional information on dietitian order writing privileges is available from the Academy of Nutrition and Dietetics.

Goal 3: Generate Clinical Research on Malnutrition Quality of Care		
Strategies[8]	**Recommendations[8]**	**Comments for State Legislators**
Identify and Fill Research Gaps by Conducting and Disseminating Relevant Research	• Conduct state research on barriers and pathways to reduce barriers to malnutrition care and nutrition support	• Potential barriers can include lack of malnutrition screening on admission to Older Americans Act nutrition programs, limited provision of malnutrition risk screening and intervention information when patient transitions to another site of care, and limited awareness of the impact of malnutrition on health outcomes
Track Clinically Relevant Nutritional Health Data	• Include clinically relevant malnutrition-related data in acute care, post-acute care, and community settings in state initiatives	• One state included malnutrition care information and community nutrition providers in the technology platform that healthcare institutional providers are using to seamlessly provide critical patient data across the continuum of care • Some states have added the collection and analysis of data on patient malnutrition to the purposes of state agencies charged with improving hospital quality of care

Goal 4: Advance Public Health Efforts to Improve Malnutrition Quality of Care		
Strategies[8]	**Recommendations[8]**	**Comments for State Legislators**
Educate and Raise Visibility with State and Local 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	• Include community leaders—church and religious leaders, community centers, older adult associations, and others—in the education campaign as they are trusted messengers with older adults and their caregivers
Integrate Malnutrition Care Goals in State and Local Population Health Management Strategies	• Initiate state-level Malnutrition Prevention Commissions or add malnutrition care scope to existing quality measures, or older adult commissions or committees, following the examples of Massachusetts, Ohio, Connecticut, and Virginia • Implement malnutrition screening standards for early identification with populations at high risk for malnutrition - Implement malnutrition screening at State Department of Health, Medicaid agencies, and hospitals, and in state telehealth programs - Integrate malnutrition screening, education, and interventions into state diabetes, obesity, and falls prevention plans	• As an example, the Massachusetts Commission on Malnutrition Prevention Among Older Adults issues an annual report to the Governor and the Commonwealth’s Legislature that outlines their accomplishments including updating local community network nutrition intake policies, strengthening data access for transitional care, and raising public awareness and identifying needs through screening programs

Taking Policy Action on Older Adult Malnutrition /

There are many different ways states can take policy action on older adult malnutrition. These include state legislation, proclamations, state resolutions for Malnutrition Awareness Week™, constituent communications, and other state-specific activities. See Appendices E, F, and G for example legislation to establish a malnutrition prevention commission, example legislation to expand the scope of the State Council on Aging, and a sample press release for malnutrition commission legislation.

State Legislation

Several states have taken the lead in legislative actions related to older adult malnutrition, including resolutions recognizing Malnutrition Awareness Week™ (a program of the American Society for Parenteral and Enteral Nutrition) and legislation establishing Malnutrition Prevention Commissions, as outlined below. See Appendix H for malnutrition policy through the decade.

Legislation		
Recognizing Malnutrition Awareness Week		
State	**Year**	
Illinois	2013-14	House Resolution 418*
Indiana	2013-14	House Concurrent Resolution 24*
Louisiana	2013-14	Senate Concurrent Resolution 41*
Ohio	2013-14	House Resolution 306*
Florida	2015-16	Senate Resolution 550*
Georgia	2015-16	Senate Resolution 254*
Texas	2015-16	House Resolution 1419*
New Mexico	2015-16	House Memorial 104*
Establishing Malnutrition Prevention Commission		
Massachusetts	2015-16	Senate Bill 2499**
Ohio	2015-16	House Bill 580**
Other		
Virginia	2016-17	Senate Bill 1437** Including strategies related to malnutrition in duties of Commonwealth Council on Aging
Connecticut	2018-19	House Bill 7338** Increasing funding for elderly nutrition, ensuring equitable rates for providers of Meals on Wheels, and collecting data on malnutrition

*Adopted/ **Passed

Proclamations and Partners

State governors and officials have made proclamations to support Malnutrition Awareness Week™. In 2020, state proclamations were issued in Alabama, Florida, Massachusetts, Nevada, New Jersey, New York, South Carolina, South Dakota, Texas, Utah, and Wisconsin. A sample resolution recognizing Malnutrition Awareness Week™ is provided in Appendix I.

In addition, multiple state leadership groups have taken specific policy actions, including the National Organization of Black Elected Leaders—Women (NOBEL-Women) adopting a malnutrition resolution in 2012, 2016, 2019, and 2020; the National Lieutenant Governors Association adopting a malnutrition resolution in 2020; and the National Conference of State Legislatures, Standing Committee on Health and Human Services adopting a policy supporting establishing malnutrition care as a measure of quality healthcare. These organizations present best practices and provide policy recommendations that can be adapted for different states.

Constituent Actions

Increasing constituent awareness about the issue of older adult malnutrition is also important. In 2020, the Florida Commissioner of Agriculture issued a proclamation and released a video, press release, and social media calling attention to the issue during Malnutrition Awareness Week™. Samples of a constituent communication, social media, an op-ed, and graphics are included in Appendices J, K, L, and M. There is a need to improve constituent awareness about malnutrition intervention too. Many state legislative offices often serve in the role of case worker to help connect constituents with state and local services and resources. There are a number of stakeholders involved in administering nutrition assistance programs (Appendix B). Constituents may benefit when provided specific resource links for meals and food assistance programs for older adults (Appendix B).

Older adult malnutrition was included in the Massachusetts Health Council's 2017 *Common Health for the Commonwealth Report on Preventable Conditions and Social Determinants of Health*. Further, state commissions and workgroups on malnutrition have published state-specific reports on older adult malnutrition, including the Massachusetts Commission on Malnutrition Prevention Among Older Adults 2018 and 2019 reports,[23] the Ohio Malnutrition Prevention Commission 2018 report, and the *State of the State: Malnutrition Among Florida's Senior Population, a Proposal for Living Healthy in Florida.*

In several individual states, stakeholders are working together in unique ways to achieve the common objectives of increasing awareness about the public health crisis of older adult malnutrition and identifying and implementing possible solutions. On the following pages are some examples of how states have approached this issue. Please contact the Defeat Malnutrition Today coalition if you would like more information on a specific state.

State Best Practices /

Connecticut

Connecticut legislators held a roundtable discussion focused on the impact of malnutrition. It was hosted by two state policymakers and several key stakeholders, including the Connecticut Nurses Association.

Additionally, an expanded network of stakeholders supported legislation, which passed in 2019, to increase funding for older adult nutrition, ensure equitable rates for providers of home-delivered meals, and collect and analyze data on malnutrition.

Florida

Advocates worked together to support the development, publication, and pull-through of a report by the Florida Department of Agriculture and Consumer Services, titled *State of the State: Malnutrition Among Florida's Senior Population, a Proposal for Living Healthy in Florida.* This report assessed malnutrition risk and impact among Florida's senior population and provided insight into potential solutions. The Florida Malnutrition Workgroup membership is geographically diverse, and its members have strong clinical backgrounds and years of experience working with older Floridians. Some members of the workgroup are the Osceola Council on Aging, Healthy St. Lucie, Lee Memorial Health, and the Florida Council on Aging. The Florida Academy of Nutrition and Dietetics leads the workgroup, whose priorities include:

- Distributing the State of the State malnutrition report
- Integrating Defeat Malnutrition Today's *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update* into the purpose of the workgroup to:
  - Ensure high-quality transitions of care
  - Consider implementation of a malnutrition screening tool during hospitalization and discharge
  - Identify quality gaps in malnutrition care
  - Define nutrition roles of the interdisciplinary team and engage nurses, social workers/case managers, and physicians
  - Track clinically relevant nutrition-related health data
- Engaging with the Florida Department of Agriculture and Consumer Services during Malnutrition Awareness Week™ and promoting activities at the state capitol, including securing approval of proclamation

Massachusetts

A malnutrition network of 24 stakeholder groups worked together to advocate for passage of a bill in 2016 to establish a Malnutrition Commission focused on older adults. The network also worked to identify nominations for the Commission membership and to follow through on the appointee process. The Massachusetts Malnutrition Commission meets regularly and submits annual reports to the governor that have included these recommendations:

- Data Collection and Management
  - Massachusetts Executive Office of Elder Affairs will require all Area Agencies on Aging (AAAs), Aging Services Access Points (ASAPs), and nutrition service providers to include the Malnutrition Screening Tool (MST) in their intake process
  - Healthcare, primary care, and other providers working across a spectrum of settings (assisted living facilities, community health centers and other outpatient settings, and food banks) should be encouraged to use the MST at intake to identify their clients/patients with high malnutrition risk
  - Hospital discharges should flag "malnutrition risk" and refer those patients for nutrition counseling at community organizations (eg, an ASAP) using the Malnutrition Quality Improvement Initiative (MQii) discharge protocol
- Public Awareness
  - An annual Massachusetts Older Adult Malnutrition Awareness Week should be established in May to align with the national Older Americans Month
  - Healthcare stakeholders should collaborate on conducting a Malnutrition Awareness Campaign at state legislative gatherings and community health promotion events
  - All member agencies of the Commission should publish and promote evidence-based malnutrition resources designed for older adults, care providers, and professionals via websites, social media, and printed materials such as newsletters
- Dissemination and Best Practices
  - National research centers or academic institutions should conduct/publish evidence-based malnutrition research as it becomes available
  - Community organizations and healthcare providers should conduct medical nutrition therapy (MNT) to treat malnutrition

Beyond the Commission, the network continues to work toward its objectives regarding malnutrition, including:

- The governor's administration's fiscal year 2020 budget proposal included a $2.4 million increase for the Senior Nutrition Program, which was a first in the Commonwealth
- The mayor proclaimed May 13 to May 20, 2019, as Older Adult Malnutrition Awareness Week in Boston, Massachusetts:
  - Throughout the week, more than 80 senior malnutrition clinics were offered and attended by 2,930 individuals
  - Screening clinics addressed misconceptions in regards to malnutrition, and individual malnutrition risk screening (using the MST) and frailty risk screening were performed
  - 82 (10%) of those screened were found at risk for malnutrition per the MST, and 15 (18%) of these had been admitted to the hospital in the last 3 months
  - Of those screened with the FRAIL scale, 99 (16%) were frail and 256 (41%) were identified as pre-frail. 23 (6%) of those screening as frail and pre-frail had been admitted to the hospital in the past 3 months
  - Findings indicated that it is important to address barriers to adequate nutrition, intervene early, and try to prevent those found at risk for malnutrition and those identified as pre-frail from progressing to frailty
- An Older Adult Malnutrition Awareness and Prevention Week webpage was created on the Massachusetts Nutrition Program for Seniors website
- The governor declared September 24 to 28, 2019, as Malnutrition Awareness Week™ in the state of Massachusetts

In 2020, the network worked with the Massachusetts Executive Office of Elder Affairs to develop and implement a social media campaign, #BeaNutritionNeighbor, that encouraged people to check in on their at-risk community members during the COVID-19 pandemic. In addition, a customized social media toolkit was disseminated in the fall during Malnutrition Awareness Week™.

On an ongoing basis, the network continues to support successful implementation of legislation and key initiatives (eg, Community Servings Food Is Medicine State Plan, Massachusetts Health Council's Indicator Report) that relate to malnutrition and the work of the Massachusetts Malnutrition Commission.

Ohio

A network of stakeholders successfully advocated for passage of Ohio Senate Bill 245, which established the Ohio Malnutrition Prevention Study Commission. The Commission was required to convene for a single term from 2017 to 2018, and submit a report to the Governor's office with their final recommendations.

Key findings of the commission's report included:

- Chronic diseases such as cancer, stroke, diabetes, and heart disease and their treatments can result in changes in nutrient intake and ability to use nutrients, which can lead to malnutrition
- In 2017, 671,333 older Ohioans were isolated and living alone; 443,770 were threatened by hunger, and 694,565 were living at or near the poverty line
- Patients who are malnourished while in the hospital have a greater risk of complications, falls, pressure injuries, infections, readmissions, and a longer length of stay, which is associated with up to a 300% increase in costs
- Malnourished hospital patients have up to five times increased mortality

With the end of the single-term commission, the group transitioned to the Ohio Malnutrition Working Group with the goal of implementing the commission's recommendations. This has led to the creation of a clinical malnutrition screening tool, which combines malnutrition and food insecurity risk screening (Appendix N). The Ohio Malnutrition Working Group piloted a study of the screening tool at the Charitable Pharmacy in Columbus. With the successful completion of that study, the working group is working to expand use of the tool with additional organizations across the state. Some stakeholders in Ohio are the Ohio Academy of Nutrition and Dietetics, the Ohio Pharmacists Association, and ASPEN.

Texas

Stakeholder partners worked together to support a study on malnutrition among older Texans, in collaboration with Texas A&M University, Texas A&M AgriLife, the Texas Academy of Nutrition and Dietetics, and Meals on Wheels. The study is now complete and lead researchers are seeking publication. Once the study is published, stakeholder partners will share and elevate key findings and continue to expand the base of stakeholder partners to support implementation of recommendations, including any policy priorities that emerge from the study.

Utah

A Utah Malnutrition Advocacy Taskforce launched in May 2020 and created a broad-based coalition of malnutrition advocates from a diverse array of organizations across the state. The focus has included developing social media and website content, newsletters, and a COVID-19 malnutrition proclamation, sharing information about ongoing malnutrition work, and laying groundwork for future policy work.

To date, the taskforce has supported a Legislative Advocacy Day at the Utah state capitol that promoted issue awareness and provided resource materials for policymakers. The taskforce also conducted a social media campaign on the need to assess and protect older adult nutrition status during COVID-19 and successfully pursued a governor's proclamation on malnutrition awareness during COVID-19.

A Quality Focus for Malnutrition Care /

(Adapted from *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update*)[8]

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. See Appendix O for a sample resolution to support addressing older adult malnutrition as a part of quality healthcare.

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) 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.[24]

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.[25] In addition, there are over 260 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—including through data sharing of related quality measures in state policies that are targeted to help decrease state Medicaid spending.

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. Further, state nutrition guidelines do not address the varying needs of older adults, yet such guidelines serve as a basis for nutrition requirements in congregate and home-delivered meal programs. A 2019 Government Accountability Office (GAO) report on nutrition assistance programs found that providers of congregate and home-delivered meal services face challenges meeting older adults' needs for certain meal accommodations.

Conclusion and Call to Action /

The time for state policymakers to enact these changes is now! Policy actions like the establishment of a Malnutrition Prevention Commission for Older Adults, recognition of Malnutrition Awareness Week™ through resolution, inclusion of strategies related to malnutrition care in state healthcare quality improvement initiatives, and addition of malnutrition goals and actions to state aging department strategic plans can help stop malnutrition. Up to one out of two older adults is either at risk of becoming or is malnourished or malnourished.[5,6] It is estimated that disease-associated malnutrition costs the United States nearly $51.3 billion annually.[1] The COVID-19 pandemic and the rapidly growing older adult population has increased urgency for policy and advocacy.

This updated toolkit outlines strategies and recommendations for establishing 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 for older adults to have the opportunity to have healthy aging with good nutrition and high-quality, safe, coordinated malnutrition care.

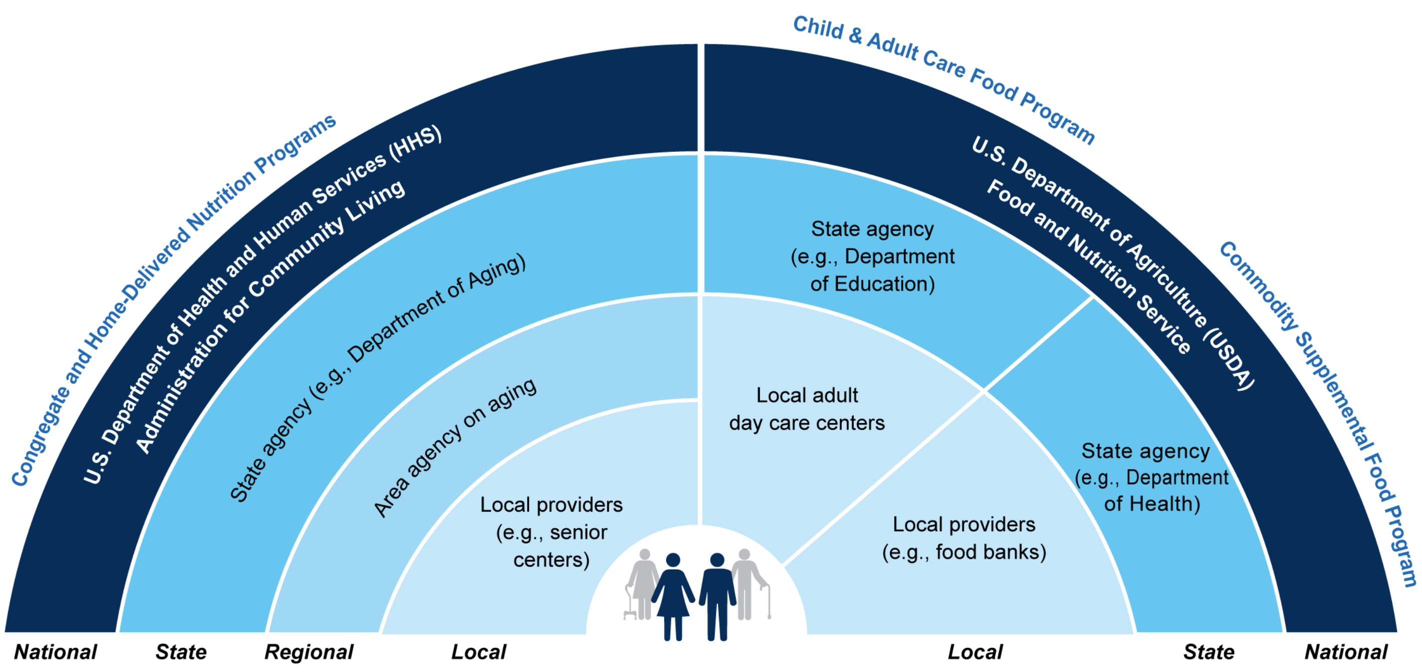
Appendix A: Federal Nutrition Assistance Programs Serving Older Adults and Opportunities for State Legislators /

Program	Eligible population	Type of assistance	No. of older adult participants in 2017	Total federal appropriations in FY 2020*	Opportunities for state 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	$266 million	This program relies on federal, state, and local funding and will benefit from state legislation supporting additional funding
Congregate Nutrition Program	Adults 60 years or older	Prepared meals provided in congregate settings, such as senior centers	1,520,507	$510 million	This program relies on federal, state, and local funding and will benefit from state legislation supporting additional funding
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	$67.9 billion	SNAP is a fully funded federal program, and older adults will benefit from state legislation 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	$245 million	This federal program may not be well-known, and older adults will benefit from promotion of information about this program
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	$4.8 billion	CACFP is not a fully funded federal program and will benefit from state 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	$18.5 million	SFMNP is not a fully funded federal program and will benefit from state legislation supporting additional funding

* Additional appropriations during the COVID-19 pandemic as of January 2021 include $925 million total for home-delivered and congregate nutrition programs and $15.8 billion for the Supplemental Nutrition Assistance Program.

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



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

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: Qualified Clinical Data Registries (QCDRs) /

A Qualified Clinical Data Registry (QCDR) is a Centers for Medicare & Medicaid Services (CMS) approved registry that collects data from reporting clinicians with the goal of improving healthcare quality. QCDR organizations may include specialty societies, regional health collaboratives, large health systems, or software vendors working in collaboration with one of these medical entities. QCDRs can be used to report quality measure data, practice improvement, and EHR use that is more specific to the quality care goals of the organization or society. CMS may also approve measures in a QCDR for MIPS (Merit-based Incentive Payment System) reporting by eligible clinicians to receive credit for quality of care. This credit is a core determining factor for performance-based payment adjustments to Medicare reimbursement as part of MIPS participation, which is mandatory for most Medicare providers who meet minimum criteria.[8]

Effective January 1, 2020, the following malnutrition-related measures, stewarded by the Academy of Nutrition and Dietetics (Academy), were adopted by the Premier Clinical Performance Registry and the US Wound Registry. In each respective QCDR, 2 measures were approved by CMS for MIPS reporting, while 2 other measures are also reportable for quality improvement but do not grant MIPS credit. The Academy has published a guide for orienting providers to MIPS participation and reporting of the malnutrition quality measures to each respective QCDR.[8]

Visit this link for the Academy's guide: https://bit.ly/and-qcdr

	Premier Clinician Performance Registry	U.S. Wound Registry
Measure #1	**Measure Title:** Completion of a Screening for Malnutrition Risk and Referral to a Registered Dietitian Nutritionist (RDN) for At-Risk Patients	**Measure Title:** Completion of a Screening for Malnutrition Risk and Referral to a RDN for At-Risk Patients
Measure #2	**Measure Title:** Assessment of Nutritionally At-Risk Patients for Malnutrition and Development of Nutrition Recommendations/Interventions by a RDN	**Measure Title:** Assessment of Nutritionally At-Risk Patients for Malnutrition and Development of Nutrition Recommendations/ Interventions by a RDN
Measure #3	**Measure Title:** Appropriate Documentation of Malnutrition Diagnosis	**Measure Title:** Obtaining Preoperative Nutritional Recommendations from a RDN in Nutritionally At-Risk Surgical Patients
Measure #4	**Measure Title:** Nutritional Care Plan Communicated to Post-Discharge Provider	**Measure Title:** Appropriate Documentation of Malnutrition Diagnosis

Key	Measures Approved for MIPS Reporting	Measures Adopted by Registry, Not Approved for MIPS Reporting

Appendix D: State Costs of Disease-Associated Malnutrition /

Estimated Annual Costs and Per Capita Costs by State of Disease-Associated Malnutrition for Adults Aged 65 Years and Older[22]

STATE	ANNUAL COSTS (AGED 65+)	PER CAPITA COSTS (AGED 65+)
Alabama	$71,968,488	$96
Alaska	$7,091,582	$100
Arizona	$95,796,376	$89
Arkansas	$42,740,348	$91
California	$492,571,488	$97
Colorado	$60,418,264	$88
Connecticut	$49,822,676	$89
Delaware	$14,656,278	$95
District of Columbia	$9,390,157	$124
Florida	$346,982,176	$91
Georgia	$125,373,000	$99
Hawaii	$31,726,716	$124
Idaho	$20,377,088	$87
Illinois	$167,950,480	$93
Indiana	$83,279,520	$88
Iowa	$41,757,180	$85
Kansas	$36,615,524	$87
Kentucky	$57,608,312	$87
Louisiana	$63,654,108	$100
Maine	$20,817,142	$85
Maryland	$84,344,672	$102
Massachusetts	$90,326,104	$88
Michigan	$141,127,008	$92
Minnesota	$67,790,480	$87
Mississippi	$43,148,340	$100
Missouri	$84,043,568	$89

STATE	ANNUAL COSTS (AGED 65+)	PER CAPITA COSTS (AGED 65+)
Montana	$15,137,121	$88
Nebraska	$23,409,542	$86
Nevada	$38,848,784	$95
New Hampshire	$18,116,064	$85
New Jersey	$124,254,664	$94
New York	$281,050,912	$90
New Mexico	$28,918,304	$96
North Carolina	$140,348,592	$95
North Dakota	$9,025,682	$86
Ohio	$162,532,560	$90
Oklahoma	$53,003,912	$92
Oregon	$56,126,272	$87
Pennsylvania	$190,557,488	$89
Rhode Island	$14,485,806	$87
South Carolina	$74,782,944	$98
South Dakota	$11,368,387	$87
Tennessee	$90,469,296	$91
Texas	$287,602,336	$92
Utah	$25,761,394	$87
Vermont	$9,114,263	$85
Virginia	$111,438,624	$96
Washington	$90,820,496	$90
West Virginia	$28,455,174	$86
Wisconsin	$76,195,096	$87
Wyoming	$7,177,984	$87
National	4,320,378,880	$93

Appendix E: Example of Legislation to Establish State Malnutrition Prevention Commission /

The following—Massachusetts Senate Bill S.1147: An Act Establishing a Commission on Malnutrition Prevention—can be adapted as needed to meet state legislative needs.

The Commonwealth of Massachusetts

In the One Hundred and Eighty-Ninth General Court (2015-2016)

An Act establishing a commission on malnutrition prevention.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 111 is hereby amended by adding the following new section.

Section XXX. There shall be a commission on malnutrition prevention within the department. The commission shall consist of the commissioner of public health or the commissioner's designee, who shall chair the commission; the secretary of elder affairs or the secretary's designee; the commissioner of the department of transitional assistance or the commissioner's designee; the commissioner of the department of agricultural resources or his designee; the co-chairs of the joint committee on elder affairs of the or the secretary of elder affairs or the secretary's designee or their designees; and nine members to be appointed by the governor, 1 of whom shall be a physician, 1 of whom shall be a university researcher, 1 of whom shall be a community-based registered dietitian nutritionist working with older Americans act funded programs, 1 of whom shall be a representative of hospitals or integrated health systems, 2 of whom shall be nurses working in home care, 1 of whom shall be a registered dietitian nutritionist working with a long-term care or assisted living facility, 1 of whom shall be a registered dietitian nutritionist representing the Massachusetts Dietetic Association, and 1 of whom shall be a representative from the Massachusetts Association of Councils on Aging, Inc.

The commission on malnutrition prevention shall make an investigation and comprehensive study of the effects of malnutrition on older adults in the commonwealth and of the most effective strategies for reducing it. The commission shall also monitor the effects of malnutrition among older adults on health care costs and outcomes, quality indicators, and quality of life measures. In addition, the commission shall: (1) Consider strategies to improve data collection and analysis to identify malnutrition risk, health care cost data and protective factors for older adults; (2) Assess the risk and measure the incidence of malnutrition occurring in various settings across the continuum of care and the impact of care transitions; (3) Identify evidence-based strategies that raise public awareness of older adult malnutrition such as through educational materials, social marketing, state-wide campaigns, and public health events; (4) Identify evidence-based strategies, including community nutrition programs, used to reduce the rate of malnutrition among older adults and reduce the rate of re-hospitalizations and healthcare acquired infections related to malnutrition; (5) Consider strategies to maximize the dissemination of proven, effective malnutrition prevention interventions including community nutrition programs, medical nutrition therapy, and oral nutrition supplements and identify barriers to those interventions; (6) Examine the components and key elements of the above malnutrition prevention initiatives, consider their applicability in the Commonwealth and develop strategies for pilot-testing, implementation and evaluation.

Appendix F: Example of Legislation to Expand Scope of State Council on Aging /

The following—Virginia Senate Bill No. 1437—can be adapted as needed to meet state legislative needs. In this bill, the scope of an existing State Council on Aging was expanded to add item 6, which focused on nutritional health, food insecurity, and malnutrition.

SENATE BILL NO. 1437
Offered January 13, 2017
A BILL to amend and reenact § 51.5-128 of the Code of Virginia, relating to Commonwealth Council on Aging; duties.

Patron—Favola
Referred to Committee on General Laws and Technology

Be it enacted by the General Assembly of Virginia:

1. That § 51.5-128 of the Code of Virginia is amended and reenacted as follows:

§ 51.5-128. Duties of the Commonwealth Council on Aging.

A. The Commonwealth Council on Aging shall have the following duties:

1. Examine the needs of older Virginians and their caregivers and ways in which state government can most effectively and efficiently assist in meeting those needs;

2. Advise the Governor and General Assembly on aging issues and aging policy for the Commonwealth;

3. Advise the Governor on any proposed regulations deemed by the Director of the Department of Planning and Budget to have a substantial and distinct impact on older Virginians and their caregivers. Such advice shall be provided in addition to other regulatory reviews required by the Administrative Process Act (§ 2.2-4000 et seq.);

4. Advocate for and assist in developing the Commonwealth's planning for meeting the needs of the growing number of older Virginians and their caregivers;

5. Assist and advise the Department with the development and ongoing review of the Virginia Respite Care Grant Program pursuant to Article 8 (§ 51.5-155 et seq.); and

6. Assist and advise the Department regarding strategies to improve nutritional health, alleviate hunger, and prevent malnutrition among older adults.

B. The Commonwealth Council on Aging may apply for and expend such grants, gifts, or bequests from any source as may become available in connection with its duties under this section, and may comply with such conditions and requirements as may be imposed in connection therewith.

Appendix G: Sample Press Release for Malnutrition Commission Legislation /

New Legislation Introduced to Help End Malnutrition in STATE

[Date] – [City, State] – The [State Malnutrition Coalition/Nutrition Stakeholders] today joined with [State Representatives/Senators] to announce legislation to help end the devastating health and economic burden of malnutrition in [State]. Simply defined as the lack of proper nutrition, often caused by not having enough to eat, not being able to eat enough because of illness or disease, or not eating enough of the right things, malnutrition can impact anyone in the US and commonly coexists with chronic health conditions like kidney disease, diabetes, and cancer. Someone can be malnourished and underweight or overweight.

Older Americans are at especially high risk of becoming malnourished for reasons such as loss of appetite, depression, living alone, limited income, and inability to shop or cook for themselves. Although it has been shown that half of US older adults are at risk for being malnourished or are malnourished, public awareness of the condition remains low and screening for malnutrition is often not conducted as part of routine healthcare for older adults. Even though it is preventable, in [State], the annual burden of disease-associated malnutrition is estimated at $[XX] for adults 65 and older. [Information can be found earlier in this toolkit]. Overall, malnutrition costs the United States $15.5 billion annually in direct medical costs. "Malnutrition is both preventable and treatable; there is no good reason for so many older Americans to be suffering from its consequences," said [Representative/Senator Name]. "We must do a better job of educating the public on the signs and symptoms of malnutrition and insisting upon screening for and treatment of malnutrition as part of routine healthcare for older Americans."

One way we can start to address older adult malnutrition in [State] is to pass [HB/SB ####]. This legislation will create a Commission on Malnutrition Prevention that will study the impact of malnutrition on [State] seniors across care settings, investigate effective strategies for reducing malnutrition, and monitor the influence of malnutrition on older adults' healthcare costs, outcomes, quality indicators, and quality of life measures. Early intervention, attention to clinical and social risk factors, routine malnutrition checks—especially during hospital stays—and caregiver awareness can all help end older adult malnutrition. We are urging fellow legislators, the healthcare community, and the public to come together to pass [HB/SB ####] to help eliminate this preventable health crisis.

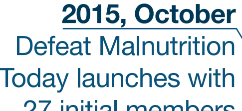
Appendix H: Malnutrition Policy Through the Decade

2013
Malnutrition quality partnership begins with goal of improving care for hospitalized older adults (quality partnership later evolves to become Malnutrition Quality Improvement Initiative [MQii])

2014
American Medical Association passes resolution recognizing need for malnutrition screenings in acute care settings

2015
Malnutrition Quality Improvement Initiative (MQii) launches with release of malnutrition electronic clinical quality measures and online toolkit

2015, July
National Black Nurses Association passes 1st national resolution recognizing nutrition as "vital sign"



2015, October
Defeat Malnutrition Today launches with 27 initial members

2016, November
Massachusetts becomes 1st state to pass legislation forming a Malnutrition Prevention Commission to study malnutrition as older adult health concern

2016, December
Ohio becomes 2nd state to pass legislation forming a Malnutrition Prevention Commission

Appendix H: Malnutrition Policy Through the Decade (cont.) /

2017

2017, March
Defeat Malnutrition Today releases 1st *National Blueprint: Achieving Quality Malnutrition Care for Older Adults*

2017, June
Defeat Malnutrition Today releases Advancing Policies for Quality Malnutrition Care in Older Adults state legislative toolkit

2017, March
U.S. Administration for Community Living issues report on preventing older adult malnutrition

2017, March
Congressional Research Service issues memo on older adult malnutrition

2017, May
Virginia passes legislation designating existing commission to study older adult malnutrition

2017, December
National Conference of State Legislatures (NCSL) adopts policy statement on older adult malnutrition

2018

2018, March
Defeat Malnutrition Today, Avalere Health, and the Academy of Nutrition and Dietetics hold national Dialogue and release report on preventing and treating malnutrition during transitions of care

2018, March
Ohio Malnutrition Prevention Commission issues state report

2018, December
Massachusetts Commission on Malnutrition Prevention Among Older Adults issues their 1st state report

2019

2019
Florida releases State of the State report on malnutrition among state's older adults

2019, January
Connecticut passes law increasing funding for older adult nutrition programs and requiring collection of state-level data on older adult malnutrition

2019, June
National Organization of Black Elected Leaders (NOBEL)-Women passes a resolution recognizing the need for malnutrition screening in all medical settings

2019, September
U.S. Senate resolution to recognize Malnutrition Awareness Week™ is introduced by Senator Chris Murphy and gains 14 senators as co-sponsors

2019, September
Journal of the Academy of Nutrition and Dietetics publishes special supplement on Malnutrition Quality Improvement Initiative

2019, December
Massachusetts Commission on Malnutrition Prevention Among Older Adults issues their 2nd state report

2019, December
Government Accountability Office releases report on older adult nutrition

2019, December
Center for Medicare and Medicaid Services approves including malnutrition clinical quality measures for reporting in two Qualified Clinical Data Registries

2020

2020, January
Defeat Malnutrition Today gains its 100th member

2020, May
Defeat Malnutrition Today releases updated National Blueprint, which references global health pandemic exacerbating malnutrition

2020, March
Older Americans Act reauthorization signed into law that adds malnutrition screening and recognizes malnutrition prevention as part of the purposes of the nutrition program

2020, November
Second US Senate resolution to recognize Malnutrition Awareness Week™ introduced by Senator Chris Murphy and gaining 22 senators as co-sponsors is passed

Appendix I: Sample Resolution Recognizing Malnutrition Awareness Week™ /

Older adults are one of the groups at greatest risk for malnutrition. However, there are other groups who are vulnerable to, and can be impacted by, the global COVID-19 pandemic and could be included in a resolution, as shown below.[8]

A resolution commending the benefits of systematic nutrition screening and intervention and recognizing the first week of September as "Malnutrition Awareness Week™" in the state of [State].

WHEREAS, experts agree that nutrition status is a direct measure of patient health and that good nutrition can keep people healthy and out of healthcare institutions, thus reducing healthcare costs, which can be up to $49 billion annually for hospital stays involving malnutrition; and

WHEREAS, inadequate or unbalanced nutrition, known as malnutrition, is particularly prevalent in vulnerable populations, such as hospitalized patients, older adults, and underserved populations, and those populations statistically shoulder the highest incidences of the most severe chronic illnesses such as diabetes, kidney disease, cancer, and cardiovascular disease that are also impacted by nutrition; and

WHEREAS, malnutrition is exacerbated by the global COVID-19 health pandemic that has intensified disparities and social isolation for older adults and is further compounded by food insecurity, and federal legislation has allocated supplemental funding for federal community nutrition programs; and

WHEREAS, illness, injury, and malnutrition can result in the loss of lean body mass, leading to complications that impact good patient health outcomes, including recovery from surgery, illness, or disease; and

WHEREAS, Enhanced Recovery After Surgery (ERAS®) care plans implemented by a team of multidisciplinary healthcare professionals can improve patient nutrition to support a strong recovery and help reduce risk of complications from surgeries; and

WHEREAS, despite the recognized link between good nutrition and good health, nutrition screening and intervention have not been systematically incorporated across the continuum of care; and

WHEREAS, clinical quality measures can help improve nutrition screening and intervention, and the Centers for Medicare & Medicaid Services (CMS) for the first time has approved multiple malnutrition-specific clinical quality measures for two CMS qualified clinical data registries; and

WHEREAS, a collaborative effort among key stakeholders in the public and private sectors continues to be required to increase awareness of, reduce, and prevent malnutrition, and the *National Blueprint: Achieving Quality Malnutrition Care for Older Adults, 2020 Update* serves as a template for such collaboration; and

WHEREAS, the [Names of Local Supporting Groups] recognize that an important step toward identifying and treating malnutrition is raising awareness about it and thus join with the American Society for Parenteral and Enteral Nutrition (ASPEN), which was the first to establish a national Malnutrition Awareness Week™ in 2012.

NOW, THEREFORE, BE IT RESOLVED by the [Legislative Body] of the State of [State] that that September XX to XX is recognized as "Malnutrition Awareness Week™" in [State] (see http://www.nutritioncare.org/maw/ for yearly dates).

Appendix J: Sample Constituent Communication Resource /

Sponsoring/Co-Sponsoring HB/SB #### Establishing a Malnutrition Prevention Study Commission

Dear Constituents,

Malnutrition is a serious and costly public health crisis—here in [State] and across our nation. Older adult malnutrition in particular is associated with unfavorable health outcomes including higher infection rates, poor wound healing, longer lengths of stay, and higher frequency of readmission. Not unexpectedly, these outcomes are associated with high costs to our healthcare system and state.

Yet, despite its severity and prevalence and the fact that it is both TREATABLE AND PREVENTABLE, older adult malnutrition is too often misunderstood by the American public and overlooked by our healthcare system.

For these reasons, I have [introduced/co-sponsored] [HB/SB ####] to begin to address this severe public health crisis among our older adults by creating a Malnutrition Prevention Study Commission. This Commission will document the problem by studying the impact of older adult malnutrition across care settings throughout the state, find evidence-based solutions by investigating the most effective strategies, and recommend systems of care to monitor the influence of malnutrition on older adults' healthcare costs, outcomes, quality indicators, and quality of life measures. This legislation is a step in the right direction to stopping malnutrition before it impacts any more of our older adults.

Please contact my office if you have any questions about the legislation or want to find out how you can help to end malnutrition in our state.

Appendix K: Sample Social Media /

The topic of older adult malnutrition can be important to your constituents. Use these sample social media posts to help increase awareness about the problem of older adult malnutrition.

Social Media Posts

TWITTER

- Quality measures for malnutrition care are needed to help ensure older Americans get the care they need
- As many as 1 of 2 older adults aged 65+ is malnourished or at risk for #malnutrition
- Malnutrition awareness is imperative for better clinical outcomes. Let's learn about and address #malnutrition in the US
- #Malnutrition is more common in the US than you think: Half of US older adults are at risk!
- Being malnourished puts Americans at risk for serious health consequences. #Malnutrition Awareness is crucial
- Did you know that obesity isn't the only nutritional epidemic in America? #Malnutrition affects thousands
- The yearly cost of disease-associated #malnutrition in older adults is more than $51.3 billion!
- Did you know that up to 1/2 of US older adults may be at risk for #malnutrition? Learn the facts & join us in speaking up
- #Malnutrition in the hospital setting often goes undiagnosed, leading to serious adverse effects
- You don't have to look unhealthy to suffer signs of #malnutrition. Learn the risk factors!
- When it comes to #malnutrition, you aren't helpless. Empower yourself and your loved ones by asking for a nutrition care plan and getting the facts

HB/SB-Specific POSTS

- Join me in supporting HB/SB#### so that we can defeat #malnutrition today!
- I introduced HB/SB#### to end the PREVENTABLE burden of #malnutrition in STATE
- HB/SB#### aims to bring #malnutrition awareness to improve clinical outcomes in our state. It is time to defeat #malnutrition today!
- Up to 1/2 of older adults are at risk for #malnutrition – Please support HB/SB#### to help us end this preventable health risk!
- #Malnutrition costs our state $_per year! HB/SB#### will help end this preventable health crisis!

Content for Specific Conditions:

Oncology

- #Malnutrition is common among cancer patients because the disease can affect the ability to digest food and absorb nutrients. http://bit.ly/1MECGSZ
- #Malnutrition is common among cancer patients. Treatment can impede the body's ability to get the best nutrition. http://bit.ly/1MECGSZ

Diabetes

- Preventing and treating #malnutrition is important in helping manage and treat diabetes and preventing or slowing complications. http://bit.ly/1MECGSZ

Kidney Disease

- Malnutrition frequently complicates chronic kidney disease and end-stage renal disease http://bit.ly/1MECGSZ
- Malnutrition can affect up to 75% of acute kidney injury and acute renal failure (ARF) patients http://bit.ly/1MECGSZ

Appendix K: Sample Social Media (cont.) /

Surgery

• Malnutrition can make recovery from surgery more challenging. Policies like Enhanced Recovery After Surgery (ERAS) help ensure surgery candidates are well nourished pre- and post-op. https://www.defeatmalnutrition.today/pt-resources

Additional Content for Facebook, Instagram, and LinkedIn:
(Note: The following content contains too many characters for Twitter)

- Do you have a family member who was affected by #malnutrition? Share your story on Instagram and Facebook using #malnutrition. You can also share your story on Defeat Malnutrition Today's website, https://www.defeatmalnutrition.today/your-malnutrition-story. Together we can make a difference and raise awareness.

- Why are we speaking up about #malnutrition? Because we want to see decreased mortality & improved quality of life. Share this status if you know someone who has suffered from #malnutrition. Take on #malnutrition. Enhance patient safety. http://bit.ly/2aMNvkQ

- Did you know that surgical patients with #malnutrition have a four times higher risk of pressure ulcer development? Learn more about malnutrition and ways to reduce these risks at http://defeatmalnutrition.today

- In some studies, 30-50% of patients become malnourished, often during a hospital stay. Educate yourself on the signs and risk factors for malnutrition at defeatmalnutrition.today

Appendix L: Sample Op-ed /

When you hear the word "malnutrition," do you think of faraway countries? Unfortunately, here in [State] and across America, malnutrition also has a face, and it is often marked by wrinkles and topped by the graying hair of an older adult.

A full-blown US public health crisis, malnutrition is hurting the health of our older adults, eroding the quality of their golden years, and contributing to our country's rising healthcare costs. Astonishingly, as many as one-half of older Americans are at risk for malnutrition and its unfavorable outcomes that include higher infection rates, poor wound healing, longer lengths of hospital stays, and higher frequency of readmissions. Even though it is preventable, in [State], the annual burden of disease-associated malnutrition is estimated at $[XX] for adults 65 and older. [Information can be found earlier in this toolkit]. Overall, malnutrition costs the United States $15.5 billion annually in direct medical costs.

These statistics are not only staggering, but completely unacceptable for a condition that is both avoidable and preventable! It's time to ensure that [State]'s seniors, their family members and caregivers, along with our healthcare community, are fully aware and on top of preventing, screening for, diagnosing, and addressing malnutrition.

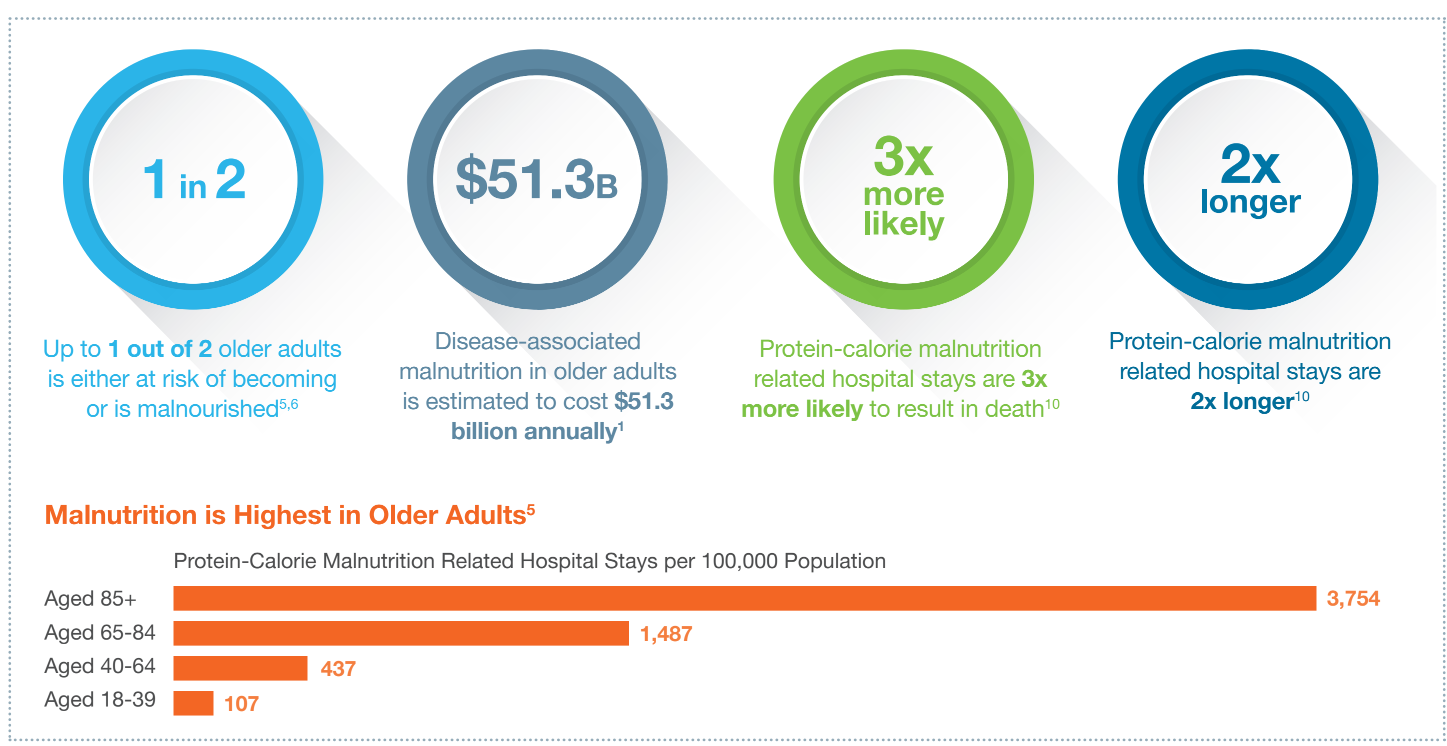
[HB/SB ####] would [establish a Malnutrition Prevention Study Commission]. This [Commission] would document the problem by studying the impact of older adult malnutrition across care settings throughout the state, find evidence-based solutions by investigating the most effective strategies, and recommend systems of care to monitor the influence of malnutrition on adults' healthcare costs, outcomes, quality indicators, and quality of life measures. I urge my colleagues in the [Committee Name] to vote "yes" on [HB/SB ####] so that we can have a good start in addressing malnutrition in our state and protecting our senior citizens.

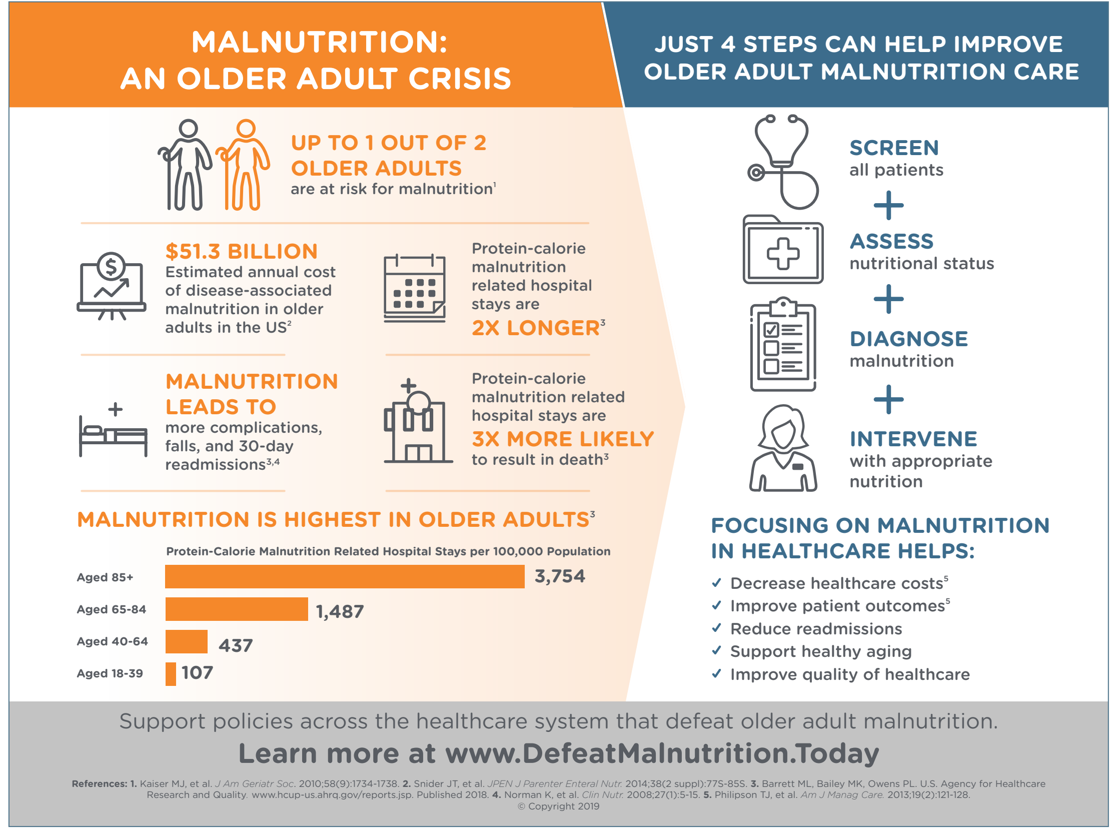
Early intervention, attention to clinical and social risk factors, routine nutrition checks—especially during hospital stays—and caregiver awareness can all help end malnutrition. I am advocating that my colleagues, the healthcare community, and the public come together to pass [HB/SB ####] to help eliminate this preventable health crisis.

[Author Name is the Title (Representative/Senator) representing District]

Appendix M: Sample Graphics /

Figure 1: Malnutrition is a Critical Public and Patient Safety Issue *(national data)*





Appendix N: 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 N: 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 O: Sample Resolution to Support Addressing Older Adult Malnutrition as Part of Quality Healthcare /

WHEREAS, malnutrition is an under-recognized and growing health crisis, with 20-50% of patients malnourished or at risk of malnutrition upon admission to the hospital, yet only 8% diagnosed with this condition; and

WHEREAS, the U.S. spends $15.5 billion per year in direct medical costs on disease-associated malnutrition, with individual states incurring a cost of $25 million to $1.7 billion yearly; and

WHEREAS, malnutrition—defined as a lack of the proper amount of essential nutrients—is common, particularly for older adults who often have a lower protein intake, thus increasing their risk of muscle wasting, which can lead to disability and poor health outcomes; and

WHEREAS, patients who are malnourished while in the hospital have a greater risk of complications, readmissions, and healthcare-acquired conditions, with patients with protein-calorie malnutrition having hospital stays that are 2 times longer; and

WHEREAS, while malnutrition is a prevalent and potentially costly problem, it is also preventable and inexpensive to treat, if addressed early, yet there continues to be a gap in the system to support improved malnutrition care; and

WHEREAS, malnutrition is often not diagnosed because malnutrition information may not be routinely communicated and tracked in hospital medical records and thus many patients fail to receive the malnutrition care they need; and

WHEREAS, electronic clinical quality measures for malnutrition care have been developed, tested, and submitted to the Centers for Medicare & Medicaid Services (CMS) and align with CMS' priorities to address clinical variations in care, improve patient outcomes, and decrease costs; and

WHEREAS, addressing older adult malnutrition requires engagement at all levels, from individuals, families, and caregivers, to healthcare institutions and providers, to public health officials and policymakers, who can all work together to support healthy aging by helping establish malnutrition care as a measure of quality healthcare.

NOW, THEREFORE, BE IT RESOLVED that the [Legislative Body] encourages the [State] Department on Aging to implement a Commission, action plan, or other public health approach to study the issue of older adult malnutrition and identify and implement effective solutions, as well as to include malnutrition screening, assessment, diagnosis, and intervention measures in state healthcare quality initiatives and care models, especially those related to clinical and social risk factors and determinants of health, transitions of care, healthcare-acquired conditions, and readmissions.

THEREFORE, BE IT FURTHER RESOLVED that [Legislative Body] urges CMS to incorporate malnutrition quality measurement into CMS quality reporting and payment programs, for the immediate benefit of older adults and the American healthcare system.

Appendix P: Glossary of Terms /

Enteral nutrition[26]: tube feeding for a person not able to eat any or enough food due to an illness or decreased appetite, difficulties swallowing, or some type of surgery that interferes with eating. The tube feeding liquid is a mixture that has protein, carbohydrates, vitamins, and minerals, given through a tube into the stomach or small intestine

Enhanced Recovery After Surgery (ERAS)[27]: a care plan to help give patients a strong recovery and help reduce complications. The focus of the plan is to have good nutrition before and after surgery to help patients have a faster, stronger recovery

Food insecurity[28]: 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[28]: 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[28]: "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[4]: 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[29]: 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[30]: 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)[31]: 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[32]: adult 65 years or older, eligible to receive Medicare

Parenteral nutrition[33]: intravenous (through the vein) administration of nutrition, which may include protein, carbohydrate, fat, minerals, and electrolytes, vitamins, and other trace elements

Qualified Clinical Data Registry (QCDR)[34]: 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[35]: 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 P: Glossary of Terms (cont.) /

Quality indicator[36]: measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality, and hence change in the quality, of care provided

Quality measures[37]: 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[38]: 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

• 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

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

• 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: https://www.youtube.com/watch?v=iPNZKyXqN1U
  - resources: http://www.agingresearch.org/malnutrition
  - press release: https://www.agingresearch.org/press-release/press-kit-for-malnutrition-a-hidden-epidemic-in-older-adults/
  - film in Spanish: https://www.youtube.com/watch?v=ADfqv42L7KI

• ASPEN Malnutrition Toolkit http://bit.ly/ASPEN-mal

• Community Malnutrition Resource Hub http://bit.ly/mal-hub

• Congressional Research Service Memo on Malnutrition in Older Adults
http://bit.ly/CRS-mal-memo

• Dialogue Proceedings, Advancing Patient-Centered Malnutrition Care Transitions
http://bit.ly/dialogue-caretrans

Resources (cont.) /

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

- Letter to CMS from House Members on Quality Measure
http://bit.ly/CMS-2019-malletter

- 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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