defeatmalnutrition.today

...vital to healthy aging

August 15, 2016

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

RE: CMS 42 CFR Parts 482 and 485, Medicare and Medicaid Programs; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care; Proposed Rule (CMS-3295-P)

Dear Mr. Slavitt,

The DefeatMalnutrition.Today coalition appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care.

DefeatMalnutrition.Today is a new and growing coalition with over 40 members who are committed to defeating older adult malnutrition. Our goals are to:

- Achieve the recognition of malnutrition as a key indicator and vital sign of older adult health
- Work to achieve a greater focus on malnutrition screening and intervention through regulatory and/or legislative change across the nation's health care system.

Proposal for Provision of Services: Authorizing Dietitians to Write Therapeutic Diet Orders in Critical Access Hospitals

We applaud CMS' recognition in the proposed rule that nutrition plays an important role in healthy patient outcomes and we agree that as stipulated, patients in critical access hospitals will benefit when registered dietitians are granted the same order writing privileges for therapeutic diets that have been granted in acute care hospitals.

Recommendations to Advance Better Care for Older Adults

As recognized in the proposed rule, early identification of Medicare beneficiaries at risk for malnutrition, prompt nutrition intervention and implementation of an effective care transition plan for patients diagnosed as malnourished or at risk of malnutrition is critical to help reduce morbidity, mortality, and costs. Despite guidelines and standards, there are variations in malnutrition care that can negatively impact time to nutrition intervention and care coordination.

As CMS seeks to improve the health of the U.S. population by supporting proven interventions to deliver higher-quality care,[1] we recommend that CMS advances other policies to ensure high-quality, timely, and coordinated malnutrition care which:

- Address malnutrition measure gaps in future quality and incentive alignment programs across healthcare settings.
- Include nutritional status and a nutrition care plan in the transfer of health information for patients, caregivers and medical providers.

This can start with the adoption of four new electronic clinical quality measures recently submitted by the Academy of Nutrition and Dietetics through the 2016 pre-rulemaking process for the Hospital Quality Reporting Program. These new electronic quality measures align with CMS priorities to address clinical variations in care, improve patient outcomes, decrease costs, and reduce burden of data collection for providers.

Our detailed comments supporting these proposals are below.

Background on the Malnutrition Problem

Malnutrition, a nutrition imbalance that affects both overweight and underweight patients, is a common issue in the acute care hospital setting. In earlier rule-making, CMS recognized a number of studies have "shown the prevalence of malnutrition among hospital patients, estimating that anywhere between 20 and 50 percent of hospital inpatients are either malnourished or at risk for malnutrition, depending on the particular patient population and the criteria used to assess these patients."[2] According to the National Resource Center on Nutrition, Physical Activity and Aging, nearly 35-50 percent of older residents in long-term care facilities are malnourished. Chronic disease increases the risk of malnutrition in older adults.

Studies estimate the prevalence of malnutrition in cancer patients is 20-87 percent,[3] in chronic kidney disease is 20-50 percent,[4] and in chronic obstructive pulmonary disease is 19-60

[1] CMS Quality Strategy

[2] Barker LA, Gout BS, Crowe TC. Hospital malnutrition: prevalence, identification and impact on patients and the healthcare system. Int J Environ Res Public Health. 2011; 8(2); 514–527

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

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

percent.[5] In addition, one of the fastest growing forms of elder abuse is self-neglect, which can be caused by the inability to maintain a proper or any diet, leading to malnutrition. Because malnutrition in older adults is often linked to economic and social factors, it can to lead to more health disparities. According to a report from the Agency for Healthcare Research and Quality, older African Americans have a significantly higher risk of malnutrition (defined as unintentional weight loss) when compared to Caucasians.[6] The Congressional Black Caucus Institute in their 21st Century Council 2015 Annual Report noted that "(t)he most benefit will occur when malnutrition care becomes a priority and routine standard of medical care." One of the steps outlined to accomplish this was "(i)ntegrating malnutrition screening and treatment into the development of evidence-based care models, such as intervention strategies to improve patient care transitions."

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

Identifying patients who are malnourished or at-risk of malnutrition is vital because, in addition to poor clinical and health outcomes, it can increase healthcare resource utilization and costs. Research documents malnourished older adults make more visits to physicians, hospitals and emergency rooms. Malnourished or at-risk patients can continue to worsen through an inpatient stay, which may also lead to increased costs. Generally, care transition programs are limited in their inclusion of nutrition-specific recommendations and practices. Studies show that malnutrition, as a contributing factor to post-hospital syndrome can increase a patient's

---

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

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

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

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

risk for a 30-day readmission, often for reasons other than the original diagnosis.[9] Malnutrition care is an important part of patient-centered care. According to a recent survey by the National Academy on an Aging Society, "Americans are aware that malnutrition can impact older adult health and independence, and they want to learn more about how to identify and treat this problem." Further, a report on the survey quotes Vice Admiral Vivek Murthy, MD, MBA, U.S. Surgeon General's statement at the 2015 White House Conference on Aging, where he explained "The way to build the foundation for a stronger America is to create a culture of prevention that has three pillars to it—strong and healthy nutrition…physical activity, and…emotional and mental well-being. We have to build and support and sustain those pillars if we want to create a culture of prevention."[10]

Malnutrition is Preventable

While malnutrition is a prevalent and potentially costly problem, it is also preventable. Effective and timely screening is essential to help providers make accurate diagnoses and early nutrition interventions have been shown to substantially reduce readmission rates,[11,12,13] as well as complication rates, length of stay, cost of care, and in some cases, mortality.[14]

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

- 28% decrease in avoidable readmissions,[15]
- 25% reduction in pressure ulcer incidence,[16]
- 14% fewer overall complications,[17]
- Reduced average length of stay of approximately 2 days,[18,19]

---

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

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

[11] Brugler L, DiPrinzio MJ, Bernstein L. The five-year evolution of a malnutrition treatment program in a community hospital. Jt Comm J Qual Improv. 1999;25(4):191-206

[12] Gariballa S, Forster S, Walters S, Powers H. A randomized, double blind, placebo-controlled trial of nutritional supplementation during acute illness. Am J Med. 2006;119(8):693-699

[13] Philipson TJ, Snider JT, Lakdawalla DN, Stryckman B, Goldman DP. Impact of oral nutritional supplementation on hospital outcomes. Am J Manag Care. 2013;19(2):121-128

[14] Tappenden KA et al. Critical role of nutrition in improving quality of care: an interdisciplinary call to action to address adult hospital malnutrition. JPEN J Parenter Enteral Nutr. 2013 Jul;37(4):482-97

[15] Gariballa S, et al. A randomized, double-blind, placebo-controlled trial of nutritional supplementation during acute illness. Am J Med 2006;119(8):693-699.

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

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

[18] Brugler L, et al. The five-year evolution of a malnutrition treatment program in a community hospital. Jt Comm J Qual Improv, 1999 Apr; 25(4):191-206

- Decreased mortality [20,21,22,23,24,25] and
- Improved quality of life. [26,27,28,29,30,31]

Recommendation for Malnutrition Quality Measures for Future Hospital IQR and VBP Programs

Early identification of Medicare beneficiaries at risk for malnutrition, prompt nutrition intervention and implementation of an effective care transition plan for patients diagnosed as malnourished or at risk of malnutrition are critical to help reduce morbidity, mortality, and costs. Despite guidelines and standards, there are variations in malnutrition care that can negatively impact time to nutrition intervention and care coordination.

While people may be at-risk or become malnourished in any setting, the trigger of a hospitalization can exacerbate and accelerate malnutrition and the risk of malnutrition. Hospitalization provides an opportunity for immediate intervention by the care team with timely (1) screening, assessment, diagnosis and nutrition intervention; (2) execution of nutrition care plan upon admission through discharge; and (3) care coordination to home or other post-acute care sites.[32]

---

[19] Smith PE, et al. High-quality nutritional interventions reduce costs. Healthcare Financial Management 1997;51:66-69.
[20] Austrums E, et al. Postoperative enteral stimulation by gut feeding improves outcomes in severe acute pancreatitis. Nutrition 2003; 19:487-491.
[21] Akner G, et al. Treatment of protein-energy malnutrition in chronic nonmalignant disorders. Am J Clin Nutr 2001;74:6.
[22] Potter J, et al. Routine protein energy supplementation in adults: systematic review. Br Med J 1998;317;495-501.
[23] Potter JM, et al. Protein energy supplements in unwell elderly patients – a randomized controlled trial. JPEN J Parenter Enteral Nutr 2001;25:323-329.
[24] Delmi M, et al. Dietary supplementation in elderly patients with fractured neck of the femur. Lancet 1990;335:1013-1016.
[25] Lacson E, et al. Outcomes associated with intradialytic oral nutritional supplements in patients undergoing maintenance hemodialysis: a quality improvement report. Am J Kidney Dis. 2012.
[26] Stratton RJ, et al. Are oral nutritional supplements of benefit to patients in the community? Findings from a systematic review. Curr Opin Clin Nutr Metab Care 2000;3:311-315.
[27] Davidson W, et al. Weight stabilization is associated with improved survival duration and quality of life in unresectable pancreatic cancer. J Clin Nutr 2004;22:239-247.
[28] Moses AW, et al. Reduced total energy expenditure and physical activity in cachetic patients with pancreatic cancer can be modulated by an energy and protein dense oral supplement enriched with n-3 fatty acids. Br J Cancer 2004;90:996-1002.
[29] Moses A, et al. An experimental nutrition supplement enriched with n-3 fatty acids and antioxidants is associated with an increased physical activity level in patients with pancreatic cancer cachexia. Clin Nutr 2001;20(suppl3):S21.
[30] Payette H, et al. Benefits of Nutritional Supplementation in Free-living, Frail, Undernourished Elderly People. J Am Diet Assoc 2002;102:1088-1095.
[31] Isenring EA, et al. Nutrition intervention is beneficial in oncology outpatients receiving radiotherapy to the gastrointestinal or head and neck area. Br J Cancer 2004;91:447-452.
[32] Tappenden K, et al. Critical Role of Nutrition in Improving Quality of Care: An Interdisciplinary Call to Action to Address Adult Hospital Malnutrition. JPEN J Parenter Enteral Nutr. 2013 Jul;37(4):482-97.

De Novo Malnutrition eCQMs for CMS Consideration for IQR and VBP

The Academy of Nutrition and Dietetics has partnered with Avalere Health and a Technical Expert Panel to develop de novo malnutrition electronic clinical quality measures (eCQMs) following the CMS Blueprint for Measure Development. The eCQMs were submitted the CMS Measures Under Consideration (MUC) List in July 2016.[33] To support quality improvement and implementation of optimal malnutrition care the Malnutrition Quality Improvement Initiative (MQII) has developed a multi-disciplinary toolkit that will be available later this year.[34] DefeatMalnutrition.Today appreciates CMS' consideration to adopt this malnutrition measure set as soon as feasible for subsequent Hospital IQR and VBP programs.

Long-Term Care Hospital Quality Reporting Measures

We also recommend considering malnutrition care quality measures for consideration in Long Term Care Hospital Quality Reporting. Malnutrition is not only a patient safety risk for hospitalized patients, it can negatively impact patient outcomes in any healthcare setting. The Coalition supports the proposed Impact Act Measure "Transfer of Health Information and care preferences when an individual transitions" and recommends CMS include nutritional status and a nutrition care plan in this transfer of health information for patients, caregivers and medical providers. In previous rule-making CMS agreed that malnutrition is an important quality measure concept for the LTCH setting.[35] **We recommend that CMS adopt a malnutrition-related quality measure in the LTCH QRP as soon as feasible**. Early identification of Medicare beneficiaries at risk for malnutrition, prompt nutrition intervention and implementation of an effective care transition plan for patients diagnosed as malnourished or at risk of malnutrition are critical to improve outcomes and patient safety by reducing complications such as infections, falls, and pressure ulcers.

We appreciate your consideration of our comments. Please feel free to contact us at **info@defeatmalnutrition.today** if you have any questions or if you need any additional information.

Sincerely,

DefeatMalnutrition.Today

---

[33] McCauley, Malnutrition Care: Preparing for the Next Level of Quality; Journal of the Academy of Nutrition and Dietetics, May 2016, http://www.andjrnl.org/article/S2212-2672(16)30012-0/fulltext

[34] Id.

[35] CMS-1632-F; Federal Register/Vol.80, No 158/Aug 17, 2015; 49748.