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Preventing and Managing Malnutrition in Older Adults

A Heightened Focus in Health Care

NUTRITION CONNECTION

Prevention and management of malnutrition continues to be a challenge, and regulatory guidance continues to strengthen the oversight of prompt interventions at the healthcare facility level. Heightened focus is also based on research validating the increased cost in healthcare spending on malnutrition, along with the negative impact on daily functioning and quality of life for older adults.

Research supports that:

- One out of every two older adults is malnourished or at risk of becoming malnourished.
- The cost of disease-associated malnutrition is estimated at $51.3 billion per year for older adults.
- Poor nutritional status causes a 300 percent increase in healthcare costs.
- Malnutrition prevalence differs based on care setting:
  - > 20-50 percent in acute care (only 7 percent of malnourished hospital patients are diagnosed)
  - > 14-51 percent in post-acute care
  - > 6-30 percent in community care
- Malnourished hospital patients are 54 percent more likely to be readmitted after 30 days.
- More than 40 percent of people age 50 and over are not getting enough protein daily.

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As a result of this heightened focus, several coalitions and alliances have formed to help raise awareness in recognizing and treating malnutrition. One organization is Defeat Malnutrition Today, which is a coalition of over 90 organizations and stakeholders working to defeat older adult malnutrition. The goals are to achieve the recognition of malnutrition as a key indicator and vital sign of older adult health risk, and a greater focus on malnutrition screening and intervention through regulatory and/or legislative change across the nation's healthcare system.

The Malnutrition Quality Improvement Initiative (MQii) is another coalition that aims to advance evidence-based, high-quality malnutrition care for patients who are malnourished or at-risk for malnutrition. The MQii is a project of the Academy of Nutrition and Dietetics, Avalere Health, and other stakeholders who provided expert input through a collaborative partnership to advance malnutrition care across the nation.

Person-centered care is still at the heart of provision of services as nutrition continues to play a vital role in helping each resident function at their highest level. It's been said that nutrition plays a key role in quality of life—and to some it *is* their quality of life. This article will present some of the recent heightened focus directives and will offer recommendations for success.

MALNUTRITION DEFINED

Malnutrition, defined as a nutrition imbalance including under-nutrition and over-nutrition, continues to permeate, but is an often under-diagnosed condition in the United States. This prevalence is worse among those who are already ill. Chronic diseases such as diabetes, cancer, and gastrointestinal, pulmonary, heart, and chronic kidney disease and their treatments can result in changes in nutrient intake and the ability to use nutrients, which can lead to malnutrition. Lack of proper evaluation and management can result in negative health and financial outcomes as malnourished adults have been found to utilize more health services with added visits to physicians, hospitals, and emergency rooms. In addition, better integration of malnutrition care into care transitions is important as older adults' transition from one point of care to another. Many times, their nutrition status is not evaluated, documented, or even included in patient health conversations.

Through an inpatient study recently published in the Journal of the Academy of Nutrition and Dietetics, researchers analyzed their hospital's monthly reports for malnourished patients admitted between March 2015 and June 2017. During this timeframe, registered dietitian nutritionists (RDNs) identified 1,817 records for malnourished adult patients. Of these patients, 64.4 percent were not coded for malnutrition.

In the acute care setting, reimbursement of services to prevent and manage malnutrition is important for several reasons. Accurate coding is important for malnutrition and impacts the assigned Medicare Severity Diagnosis Related Groups (MS-DRG), appropriately bringing greater reimbursement for the hospital stay and establishing suitable comparison benchmarks such as expected length of stays (LOS). Accurate coding also informs the Centers for Medicare & Medicaid Services' (CMS) ongoing efforts to refine the MS-DRG system. Consistent use of standardized criteria,

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such as that published by the Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition (ASPEN) to determine the presence of severe and nonsevere malnutrition, aids ongoing efforts to predict financial costs and outcomes associated with preventing and treating malnutrition.

The current heightened awareness of malnutrition is taking on new importance in nursing homes as it is a reimbursement element of the new Patient Driven Payment Model (PDPM). PDPM is a case-mix classification system for classifying skilled nursing facility (SNF) patients in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System. Beginning October 1, 2019, PDPM will replace the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).

The PDPM classification methodology utilizes a combination of six payment components to derive payment. Five of the components are case-mix adjusted to cover utilization of SNF resources that vary according to patient characteristics. There is an additional non-case-mix adjusted component to address utilization of SNF resources that do not vary by patient. Different patient characteristics are used to determine a patient's classification into a case-mix group (CMG) within each of the case-mix adjusted payment components.

Under PDPM, CMS identified 50 conditions that were related to increases in Non-Therapy Ancillary (NTA) costs in the SNF. CMS recognizes there is an added cost for caring for residents with these conditions and will reimburse nutrition services for residents with a diagnosis of malnutrition, morbid obesity, parenteral IV feedings and enteral feedings. As always, medical record documentation to support the diagnosis and provision of nutrition services is critical and should reflect proper screening, diagnosis, nutrition assessment criteria with prompt interventions.

FACILITY SYSTEMS FOR SUCCESS

Successful outcomes in prevention and management of malnutrition require a team effort and having clear systems and processes in place. The following recommended three steps can help improve older adult malnutrition:

Implement a Validated Malnutrition Risk Screening Tool

Despite knowing that early detection and prompt treatment are essential in preventing and managing malnutrition, early identification of clinical criteria supporting malnutrition diagnosis and effective processes for communicating information related to the nutrition care process are often absent. In those who are already malnourished, treatment may reverse malnutrition and effectively reduce mortality and complication rates. Early detection, therefore, becomes crucial in the older adult.

It is important to use a validated screening tool that is reliable for identifying malnutrition risk in adults across care settings, acute and chronic medical conditions, and ages. Validity is important because validated tools have been proven to measure what they claim to measure in a specific population and detect those who truly have the condition.

The Academy of Nutrition and Dietetics ranked the following screening tools based on the strength of the

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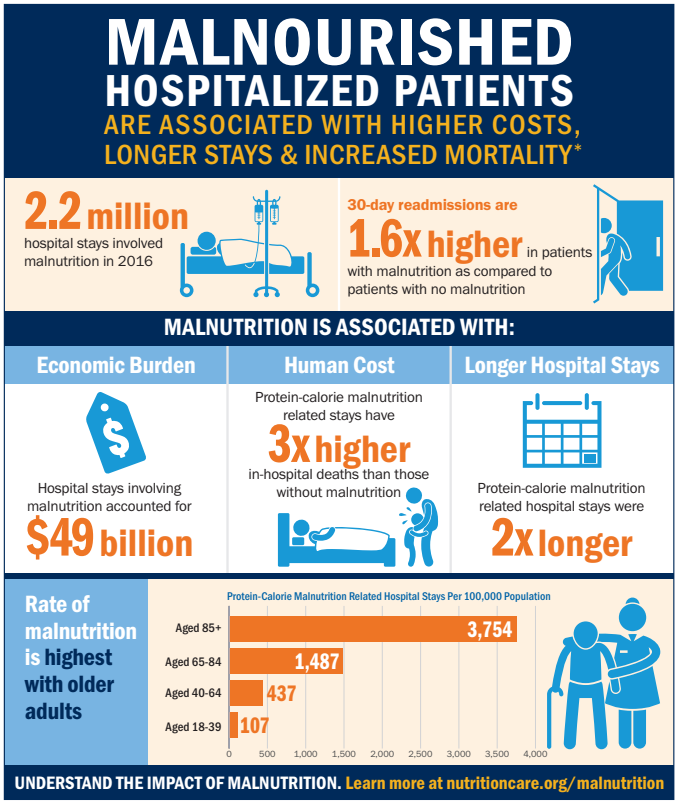

**Barnett ML, Bailey MK, Owens PL. Non-maternal and Non-neonatal Inpatient Stays in the United States Involving Malnutrition, 2016. ONLINE. August 30, 2018. U.S. Agency for Healthcare Research and Quality. Available: www.hcup-us.ahrq.gov/reports.jsp. Source: American Society for Parenteral and Enteral Nutrition*

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supporting evidence, the validity, reliability and agreement results, and the generalizability of six screening tools from highest to lowest as follows:

- Malnutrition Screening Tool (MST)
- Malnutrition Universal Screening Tool (MUST)
- Mini Nutrition Assessment-Short Form (MNA-SF)
- Short Nutritional Assessment Questionnaire (SNAQ)
- Mini Nutritional Assessment-Short Form-Body Mass Index (MNA-SF-BMI)
- Nutrition Risk Screen-2002 (NRS-2002)

Initiate Prompt Referral and Nutrition Assessment by the RDN

Following a malnutrition risk screening, prompt referral to the RDN for a nutrition assessment with recommended medical nutrition therapy is the next step in malnutrition prevention and management. The nutrition assessment by the RDN is also vital to provide the diagnostic criteria for malnutrition required in the medical record. The CDM and NDTR play important roles in the overall review, collection of data, and communication to provide the RDN with timely and accurate information for the overall assessment.

Over the years there has been little consensus on the criteria used to diagnose malnutrition. The need for consensus in criteria used for diagnosing malnutrition has resulted in global efforts to develop core "best practice"

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diagnostic criteria. In January 2016, the Global Leadership Initiative on Malnutrition (GLIM) was convened by several of the major global clinical nutrition societies. GLIM appointed a core leadership committee and a supporting working group with representatives bringing additional global diversity and expertise. GLIM builds upon the ASPEN and Academy of Nutrition and Dietetics consensus statement guidelines for identification and documentation of adult malnutrition, and includes a recommended two-step approach for the malnutrition diagnosis. The first step is screening to identify "at risk" status using a validated screening tool, and the second step is assessment for diagnosis and grading the severity of malnutrition.

The overall diagnoses are included in the overall assessment and followed by recommended "person-centered" nutrition interventions with facility monitoring for appropriateness and revisions as needed.

Incorporate Facility Interventions and Performance Improvement

Prevention and management of malnutrition requires a collaborative team effort at the facility level. Food, dining, and nutrition services are provided in some way by almost all facility staff. Clearly communicated "best-practice" systems and processes must be in place with consistent training and education.

Some recommendations for success include:

- Incorporating Step 1 (Use a validated malnutrition risk screening tool) and Step 2 (Provide prompt referral and nutrition assessment by the RDN).
- Clearly define the role of the RDN/NDTR/CDM in facility programs, systems, and processes within their Scope of Practice for screening, assessment, and interventions.
- Integrate nutrition status considerations into facility existing protocols, policies, and procedures.
- Educate all staff about the impact of malnutrition/poor nutrition, and their role in identifying it, and the importance of nutrition interventions. Make sure staff has the competencies and skills to prevent and manage malnutrition.
- Understand the reimbursement and regulatory requirements related to nutrition, and implement facility-specific programs to support compliance.

IT IS IMPORTANT TO USE A validated screening tool that is reliable for identifying malnutrition risk in adults across care settings, acute and chronic medical conditions, and ages.

- Adopt standardized malnutrition terminology and clinical standards in electronic health records (EHRs) to improve malnutrition risk identification and data transfer across care settings.
- Provide information to family members and significant others about the importance of food, nutrition, and dining in preventing or managing malnutrition for their loved one(s). Let them know how to notify staff if they have concerns.
- Incorporate nutrition, food, and dining services into the facility Quality Assurance and Performance Improvement (QAPI) program to enhance outcomes and measure success.

SUMMARY

The CDM with the RDN and NDTR play important roles in preventing and managing malnutrition. Through a collaborative "team" approach we can reduce malnutrition, healthcare costs related to malnutrition, and hospital admission and readmissions. We can also improve the overall nutritional intake of older adults and their quality of life. It is imperative to focus on prompt validated screening, referral to the RDN for nutrition assessment that includes diagnostic criteria for those at risk or already having malnutrition. Needless to say, the screening, assessment, and diagnosis must be followed by implementing "person-centered" nutrition interventions not only focused on managing malnutrition, but also helping each individual enhance their quality of life. E

REFERENCES AND RESOURCES

- State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents (Rev. 11-22-17) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html
- CMS Patient Driven Payment Model Website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html
- Defeat Malnutrition Today https://www.defeatmalnutrition.today/
- Malnutrition Quality Improvement Initiative (MQii) http://malnutritionquality.org/resources.html
- Consensus Statement: Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition). Jane V. White, PhD, RD, FADA; Peggi Guenter, PhD, RN; Gordon Jensen, MD, PhD, FASPEN; Ainsley Malone, MS, RD, CNSC; Marsha Schofield, MS, RD; the Academy Malnutrition Work Group; the ASPEN Malnutrition Task Force; and the ASPEN Board of Directors. Journal of Parenteral and Enteral Nutrition, Volume 36 Number 3, May 2012 275-283 © 2012 American Society for Parenteral and Enteral Nutrition and the Academy of Nutrition and Dietetics DOI: 10.1177/0148607112440285 http://jpen.sagepub.com hosted at http://online.sagepub.com
- GLIM criteria for the diagnosis of malnutrition - A consensus report from the global clinical nutrition community. T. Cederholm, G.L. Jensen, M.I.T.D. Correia, M.C. Gonzalez, R. Fukushima, T. Higashiguchi, G. Baptista, R. Barazzoni, R. Blaauw, A. Coats, A. Crivelli, D.C. Evans, L. Gramlich, V. Fuchs-Tarlovsky, H. Keller, L. Llido, A. Malone, K.M. Mogensen, J.E. Morley, M. Muscaritoli, I. Nyulasi, M. Pirlich, V. Pisprasert, M.A.E. de van der Schueren, S. Siltharm, P. Singer, K. Tappenden, N. Velasco, D. Waitzberg, P. Yamwong, J .Yu, A. Van Gossum, C. Compher, https://doi.org/10.1016/j.clnu.2018.08.0020261-5614/© 2018 Elsevier Ltd, European Society for Clinical Nutrition and Metabolism and American Society for Parenteral and Enteral Nutrition

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1. The cost of disease-associated malnutrition is estimated at $____ billion per year for older adults.
   A. 45.5
   B. 51.3
   C. 55.5
2. More than ____ percent of people age 50 and over are not getting enough protein daily.
   A. 35
   B. 40
   C. 45
3. Malnutrition is often an _____ diagnosed condition in the U.S.
   A. Under
   B. Over
   C. Excessively
4. Accurate coding in the acute care setting impacts the CMS reimbursement and benchmarking for length of stay (LOS) system called:
   A. Medicare Severance Delayed Groupings (MS-DRG)
   B. Medicare Severity Diagnosis Related Groups (MS-DRG)
   C. Medicare Solvency Determination Related Groupings (MS-DRG)
5. The new case-mix classification system for classifying skilled nursing facilities in a Medicare Part A covered stay into payment groups is called:
   A. Patented Diagnostic Payment Model (PDPM)
   B. Predetermined Diagnosis Payment Model (PDPM)
   C. Patient Driven Payment Model (PDPM)
6. Several key non-therapy ancillary nutrition diagnoses and conditions that will be reimbursed for nutrition services under PDPM include:
   A. Malnutrition, morbid obesity, parenteral IV feedings, enteral feedings
   B. Malnutrition, obesity, parenteral IV feedings, enteral feedings
   C. Nutrition, obesity, parenteral IV feedings, enteral feedings
7. The following steps can improve older adult malnutrition:
   A. Facility designed nutrition risk screening, RDN referral and assessment, effective facility interventions
   B. Facility designed nutrition risk screening, RDN, facility interventions
   C. Validated nutrition risk screening, RDN referral and assessment, effective facility interventions