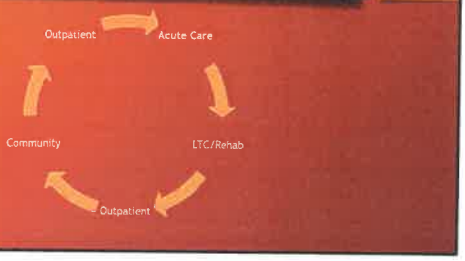
Malnutrition In Post Acute Care: Practical Strategies To Stop the Decline

Presented by Julie Grim MPH, RDN, LD
March 26, 2019

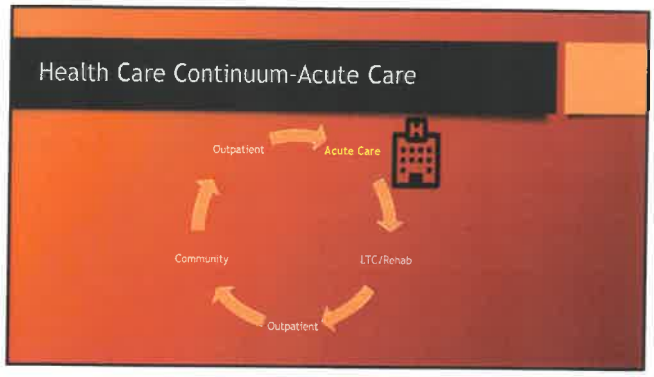
Presentation Objectives

- Describe benefits of MQii and application to PALTC RDNs
- Identify effective innovations that improve patient/resident transitions between acute and post-acute care to reduce risk of malnutrition
- Identify immediate steps to better integrate malnutrition identification and intervention into care pathways and models.

The Health Care Continuum



Health Care Continuum-Acute Care



Malnutrition in Acute Care

- What do we already know ?
- Reported incidence 30%-50% of hospitalized patients
  - Worse outcomes:
    - Poor wound healing
    - Infection
    - Longer length of stay
    - Higher risk of readmission
    - More expensive to treat
    - Higher odds of mortality

Clinical Impact of Malnutrition

Malnutrition Identified by Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition in Assistance With Major 30-Day Readmissions, Greater Hospital Mortality, and Longer Hospital Stays: A Retrospective Analysis of Nutrition Assessment Data in a Major Medical Center

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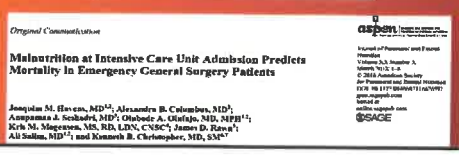

Original Communications

Malnutrition at Intensive Care Unit Admission Predicts Mortality in Emergency General Surgery Patients

Joaquin M. Hevia, MD[1,2]; Alexandra B. Columbus, MD[3]; Anupama J. Seshadri, MD[3]; Olubode A. Olufajo, MD, MPH[1,2]; Kris M. Mogensen, MS, RD, LDN, CNSC[4]; James D. Rawn[3]; Ali Salim, MD[1,2]; and Kenneth B. Christopher, MD, SM[1,2]

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SAGE

New!! GLIM Criteria for the Diagnosis of Malnutrition

- Top 5 Criteria for the Diagnosis of Malnutrition
  - Nonvolitional weight loss
  - Low Body Mass Index (BMI)
  - Reduced Muscle Mass
  - Reduced food intake or assimilation
  - Disease Burden/Inflammation

Jensen et al JPEN 2019

GLIM Criteria for the Diagnosis of Malnutrition

Table 3. Phenotypic and Etiologic Criteria for the Diagnosis of Malnutrition.

Phenotypic Criteria[a]			Etiologic Criteria[a]	
Weight Loss (%)	Low Body Mass Index (kg/m²)	Reduced Muscle Mass[b]	Reduced Food Intake or Assimilation[c,d]	Inflammation[e,f,g]
>5% within past 6 months, or >10% beyond 6 months	<20 if <70 years, or <22 if >70 years Asia: <18.5 if <70 years, or <20 if >70 years	Reduced by validated body composition measuring techniques[h]	≥50% of ER x 1 week, or any reduction for >2 weeks, or any chronic GI condition that adversely impacts food assimilation or absorption[c,d]	Acute disease/injury[e,f] or chronic disease-related[f,g]

Need 1 phenotype and 1 etiologic criteria to be diagnosed with malnutrition

Jensen et al JPEN 2019

GLIM Criteria for the Diagnosis of Malnutrition

Table 4. Thresholds for Severity Grading of Malnutrition Into Stage 1 (Moderate) and Stage 2 (Severe) Malnutrition.

	Phenotypic Criteria[a]		
	Weight Loss (%)	Low Body Mass Index (kg/m²)[b]	Reduced Muscle Mass[c]
Stage 1/moderate malnutrition (requires 1 phenotypic criterion that meets this grade)	5%–10% within the past 6 months, or 10%–20% beyond 6 months	<20 if <70 years, <22 if ≥70 years	Mild-to-moderate deficit (per validated assessment methods; see below)
Stage 2/severe malnutrition (requires 1 phenotypic criterion that meets this grade)	>10% within the past 6 months, or >20% beyond 6 months	<18.5 if <70 years, <20 if ≥70 years	Severe deficit (per validated assessment methods; see below)

Jensen et al JPEN 2019

GLIM Criteria for the Diagnosis of Malnutrition

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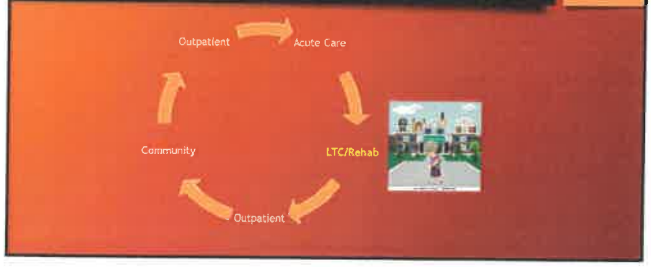
Jensen et al JPEN 2019

MQii

- What is the MQii?
  - Collaborative Partnership of the Academy of Nutrition and Dietetics, Avalere Health and other stakeholders
- How can you benefit?
  - MQii Tool Kit
  - eCQMs
  - Learning collaboratives

Health Care Continuum- Post Acute Care



Post Acute Long Term Care

- Care challenges of an aging population
  - Increased numbers
  - Higher incidence of malnutrition
  - Higher incidence of chronic disease
- Increase transfer between different levels of care
  - 40% of Medicare beneficiaries receive PALTC services[3]
  - EHR and interoperability challenges in post-acute care

Moments of Truth: Impact of Poor Communication

- Common Transition Mishaps
  - Diet orders
  - Tube feeding product/pathway
  - Self Feeding Ability
- What to Communicate?
  - Anthropometrics, especially measured weights
  - Malnutrition classification
  - What degree? What context
  - Current intervention
  - Contact information

Electronic Health Records: Challenge or Opportunity ?

- Electronic Health Record (EHR) Adoption Statistics
  - Inpatient
  - Physician office
  - SNF /Rehab
- Reasons sited for the lag
  1. Cost
  2. User perceptions
  3. Implementation problems

ONC Data Brief, 2017

Long Term Care Adoption Levels

Levels of Adoption:

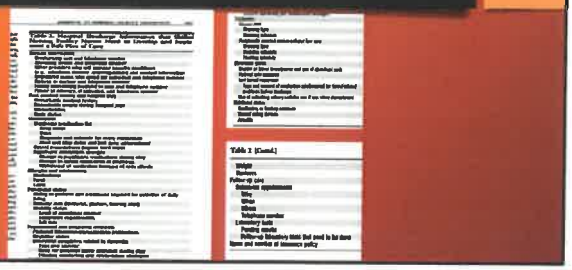
1)Basic adoption (64%)

2) True interoperability (7%)[6]

Ability for systems and devices to (send and receive, find and interpret and integrate the shared data.

- Potential impact on nutrition care

Hospital Discharge Information that Skilled Nursing Facility Nurses Need to Develop and Implement a Safe Plan of Care[7]



Hospital Discharge Information that Skilled Nursing Facility Nurses Need to Develop and Implement a Safe Plan of Care[7]

- Key Findings:
  - Perception: Difficult hospital/SNF transitions are the norm
  - Much info for plan of care missing, incomplete, inaccurate, conflicting
  - Poor quality D/C information major barrier to safe and effective transitions
- Recommendations:
  1. hospitals need to communicate medical information at least 24 hours before SNF admission to ensure that needed medications and special equipment are available
  2. Health Care professionals need transitional care training to understand the needs and resource limitations of non hospital settings

Regulatory Changes in Post Acute Care

- Impact Act, 2014
  - Reform of post acute payment and reimbursement
  - Substantial penalties for readmissions with 30 days of discharge
- CMS 2017 change to core quality of care regulations
  - Care for severely ill/frail elderly
  - Change toward person centered care
    - Significant updates to requirements for
      - Skin integrity
      - Mobility
      - Assisted nutrition and hydration
      - Parenteral nutrition and dialysis
  - Value based purchasing incentives/penalty for readmissions within 30 days final rules[8]

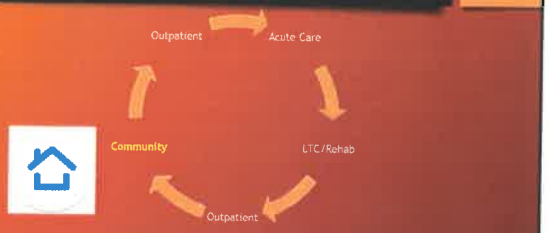
Communication of Information Paradox

- Much information is needed
- RD time is limited
- Systems do not support
- Discharge planning staff are not aware of or do not prioritize nutrition related data needs
- Malnutrition impacts readmission rates
- Documentation requirements for care and D/C planning are substantial
- Lack of published, high quality data on impact

Communication Priorities- Take the Initiative!

1) What are the top 5 facilities you receive referrals from?
2) What challenges do you have receiving information from those facilities
3) Identify what critical information you need (top 5 must haves!)
4) Develop relationships
   - Get their contact information!
   - Who are the RDs? Who are other key clinicians you may want to talk to?
   - How do they like to communicate?
     - Get email - if you are sending patient info, make sure it's secure!
     - Or, email to set up a time to talk - a "warm handoff" for a complex patient can make a huge difference in the patient's care
     - Utilize texting as able within HIPAA requirements

Health Care Continuum



What level of services do they need at home?

- Home delivered Meals ?
- Home infusion services ?
- Food assistance ?
- Special Diet?
- Other?

- What do you communicate to bridge that transition?

Ambulatory Care Transition Challenges

- Malnutrition not well identified in the outpatient setting
- Large gap between estimated incidence of malnutrition in the acute care setting and diagnosis at discharge[1]
- Many patients continue to lose weight after discharge increasing risk of malnutrition.
- Malnourished hospital patients are 54% more likely to be readmitted post discharge[9]
- US Council on Aging estimates 1 out of 2 older Americans at risk for malnutrition (even higher for older adults in hospitals and long term care facilities)[10]
- Nutrition Screening in the ambulatory care setting limited or none at all

Nutrition Screening in the Ambulatory Setting: Setting: The Problem:

- Lack of awareness
- Lack of time
- Lack of adoption of standardized malnutrition terminology and clinical standards across care settings to support data transfer
- Not currently mandated unless clinic is a hospital outpatient clinic
- Provider financial incentives not aligned

Ambulatory Care Transition Challenges The Problem Continued...

- **Food Insecurity remains a significant problem**
  - 41 million people are food insecure hunger in the USA including 13 million children[11]
  - Incidence of Food Insecurity in the United States was 12.9% in 2016 [1]
  - 1 in 4 Meals on Wheels Programs in the USA has a waiting list[12]

Case Study: Nutrition Risk/Food Insecurity

- 364 Patients on extended home health care were contacted by Community Health Workers
  - (CHWs) employed by physician practices in urban and suburban communities in Texas to determine potential unmet needs related to the social determinants of health.
- Social determinants included:
  - Need for chronic disease education, access to care, insurance benefits
  - Food insecurity
  - Transportation
  - Isolation/socialization
  - Durable medical equipment needs
- 235 (65%) were identified as food insecure
- Interventions: Meals on Wheels set up, church pantry locations, and senior feeding sites

Nutrition Screening in the Ambulatory Setting: Potential Solutions

- Validated, easy to use screening tools
  - Mini Nutrition Assessment (MNA)
  - Hunger Vital Signs
- After visit summary tools
- Incorporation into annual Medicare wellness exam

No	0
Unsure	2
If Yes, how much weight (kg) have you lost?	
1 – 5	1
6 – 10	2
11 – 15	3
> 15	4
Unsure	2
Weight Loss Score:	
Have you been eating poorly because of a decreased appetite?	
No	0
Yes	1
Appetite Score:	

Food Insecurity Screening and Resources

1) The Hunger Vital Sign ™ (HVS)
   - "Within the past 12 months we worried whether our food would run out before we got money to buy more"
   - Within the past 12 months, the food we bought just didn't last and we didn't have money to get more"[13]
2) Resource Templates

Growing Focus On Social Determinants of Health

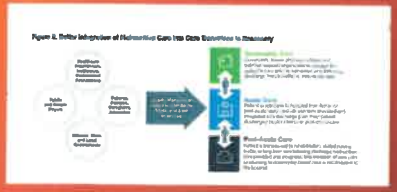
Innovative Programs and Collaborations to Address Food Insecurity

- Home Delivered Meals /Hospital Collaborations
- Food Pharmacies
- "Healthy Cities" Dallas
- Embedded clinic health advocates
- North Texas Food Bank "Food for Health"

Therapeutic Home Delivered Meals

- Advances
- Research
- Add on services
- Reimbursement potential in ACO models

Potential Framework for Integrating Malnutrition Care into System-Level Pathways



Dialogue Proceedings Advancing Patient-Centered Malnutrition Care transitions., 2016

Strategies to More Effectively Manage Care Transitions

Low Tech/High Touch	High Tech
1)Warm Handoffs 2)Learn about the nutrition resources available in the communities you serve and establish direct contact with the organizations 3)Identify top 5 facilities who transfer you patients or vice verse. Meet the RD, case manager or discharge planner and obtain their contact info 4) Know the discharge planning clinicians and intake team at your facilities 5) Get comfortable with sharing readmission statistics related to malnutrition with health care team members and administrators 6) Learn, learn, learn!	1) Leverage EHR (when possible) to prepare discharge plan and coordinate care post-hospitalization. If possible via EHR linking, allow for auto-population of diagnosis into discharge plan 2) Work with your EHR team to expand use of hard stops and alerts to make nutrition information more visible and enhance decision making 3)Include inpatient malnutrition diagnosis and nutrition intervention plan in the discharge summary

Know Your Resources

Practice Applications

1. Integrate nutrition status considerations into existing protocols, pathways and models (e.g., disease-specific protocols and pathways or care transition models.
2. Identify community resources to address hunger and malnutrition and share with your care team.
3. Get to know the nutrition providers in the locations where you transfer patients back and forth most often.

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