WHAT WE LEARNED

Significant opportunities exist to facilitate improved care for patients with poor nutrition or malnutrition as they transition across care settings; operating multiple multi-stakeholder recommendations to advance screening and nutrition care; data infrastructure, and patient education and shared decision making can address these needs and improve patients’ overall health.

BACKGROUND

Malnutrition—both under and overnutrition—is an important issue that can impact functionality, healthy aging, and quality of life. Malnutrition affects individuals in acute, post-acute, and community settings alike, and includes overweight and obese individuals who lack sufficient nutrition. (Figure 1)

Care coordination and smooth transitions across the care continuum are critical for impact functionality, healthy aging, and quality of life. Malnutrition affects individuals in acute, post-acute, and community settings alike, and includes overweight and obese individuals who lack sufficient nutrition. (Figure 1)

METHODS

Consistently adopt into care coordination models (e.g., the patient-centered medical home) and quality improvement and health management solutions (e.g., comprehensive shared care plans, the transitional care model, or risk-stratification models) or across care settings, particularly as patients transition care.

OBJECTIVES

1. To understand barriers to better integration of malnutrition care into system-level care pathways.

2. To identify opportunities for screening and nutrition care, patient education and shared decision making, and care coordination to facilitate improved transitions for patients with poor nutrition or malnutrition between care settings.

METHODOLOGY

Avalere Health, the Academy of Nutrition and Dietetics (“the Academy”), and the Defeat Malnutrition Today Coalition convened a national Dialogue event, “Advancing Patient-Centered Malnutrition Care Transitions” on March 14, 2018 in Washington, D.C. The event brought together multi-stakeholder representatives of organizations engaged in the delivery of care or support for malnourished and at-risk individuals, including clinicians (e.g., physicians, dietitians), social workers, payers, professional societies, patient/caregiver advocacy groups, and community-based service providers, to address malnutrition-focused transitional care gaps. The objectives of the day-long Dialogue were to:

1. Evaluate the current state of care transitions for malnourished patients and identify key barriers to maltreatment.

2. Identify high-priority care transition gaps and opportunities to address these gaps across the care continuum.

3. Outline core considerations for integrating malnutrition care into system-level care pathways to support patient goals and improve outcomes.

In anticipation of the Dialogue, we conducted a targeted literature search of white and grey literature to understand care delivery mechanisms across acute, community, and post-acute settings. We searched PubMed and Google Scholar to identify literature, guidelines, and clinical consensus documents focused on nutrition, as well as a review of nutrition-focused tools, quality measures, data sources (i.e., registries, QIFs), quality improvement programs, and key stakeholders. In total, we performed a full review of 98 studies.

RESULTS

Multi-stakeholder input received during the Dialogue, as well as findings from the literature review, highlighted a significant opportunity to better integrate malnutrition care standards, tools, and best practices into patients’ care as they transition across care settings (Figure 3).

Figure 3. Better Integration of Malnutrition Care into Transitions is Necessary

To do so, participants noted the need for better screening and nutrition care, patient education and shared decision making, and data infrastructure to support improved coordination, communication and patient engagement in addressing nutrition care. Specifically, the pilot will aim to ensure interventions and follow-ups for nutrition care are consistently adopted into care coordination models (e.g., the patient-centered medical home) and care transition pathways or models (e.g., comprehensive shared care plans, the transitional care model, or risk-stratification models) or across care settings, particularly as patients transition care.

CONCLUSIONS

The Dialogue outlined ways that clinicians, community and social service providers, patients and caregivers, payers, and policymakers can partner to address malnutrition care gaps and operationalize recommendations that (1) support systematic nutrition screening and care, (2) provide better education and shared decision making to patients and their caregivers, and (3) improve data infrastructure to capture and share critical nutrition information.

To implement some of these recommendations, we will establish a pilot to advance systematic identification, treatment, and management of patients who are malnourished or at risk for malnutrition as they transition across care settings. The pilot will seek to engage health care teams and community-based clinicians and service providers (e.g., primary care group practices, dietitians, meal providers, and others) to integrate patient-centered nutrition care into existing care transition pathways or models. Specifically, the pilot will aim to ensure interventions and follow-ups for nutrition care are in place when patients are discharged from the hospital and to improve recognition and management of patients’ nutrition risk prior to their admission to a hospital and/or as a component of chronic disease management. Other stakeholders should similarly seek to integrate optimal nutrition care into care coordination models and programs.

REFERENCES


Figure 4. Framework for Integrating Malnutrition Care into Transitions Is Necessary

Figure 5. Recommendations to Advance Malnutrition Care as Patients Transition Across Care Settings

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