

Why Implement the MQii in Your Facility



MALNUTRITION QUALITY
IMPROVEMENT INITIATIVE

These materials were developed by the Malnutrition Quality Improvement Initiative (MQii), a project of the Academy of Nutrition and Dietetics, Avalere Health, and other stakeholders who provided guidance and expertise through a collaborative partnership. Support provided by Abbott.

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Section Takeaways

Following your completion of this section, you will know:

- The importance and impact of best practice malnutrition care to your organization
- How implementing the MQii could improve malnutrition care in your organization

The Case for the MQii

Malnutrition is most simply defined as the inadequate intake of protein and/or energy over prolonged periods of time and can include under- and over-nutrition. Malnutrition results in loss of fat stores and/or muscle wasting including starvation-related malnutrition, chronic disease-related malnutrition, and acute disease or injury-related malnutrition.^[3]

Malnutrition is a leading cause of morbidity and mortality, especially among older adults.

20-50 percent of patients are at risk of malnutrition or already malnourished upon hospital admission^[1]

Evidence suggests that 20 to 50 percent of patients are at risk for malnutrition or are already malnourished at the time of hospital admission,^[4] but only 8 percent receive a diagnosis of malnutrition – meaning many patients may be going unrecognized and untreated.^[5] The inability to identify and diagnose these patients leaves them at risk for other medical complications.

Older adults age 65+ years in particular are at an increased risk of malnutrition.^[6] As many as 65 percent of older adults admitted to the hospital may be malnourished.^[6] Given that increased age is a major risk factor for malnutrition and its associated complications, malnutrition can further exacerbate the risk of poor outcomes in this age group.

Furthermore, patients who are malnourished while in the hospital have a greater risk of complications, readmissions, hospital-acquired conditions, and increased length of stay.^[3,5]

Malnutrition increases hospital length of stay by 4 to 6 days & costs by up to 300 percent^[3]

A 2016 analysis of U.S. hospital discharges reported that average hospital costs for all non-neonatal and non-maternal hospital stays were \$12,500, while patients diagnosed with malnutrition had hospital costs averaging up to \$25,500 depending on the type of malnutrition indicated.^[7] Further, readmissions associated with malnutrition have an average cost per readmission of \$16,900 per patient for those with protein-calorie malnutrition and \$17,900 per patient for those with post-surgery nonabsorption. This is 26 and 34 percent higher respectively than readmissions costs for patients without malnutrition.^[8]

Yet despite the evidence that demonstrates the benefits of nutrition for healing and recovery, and a clinical consensus model for implementing optimal malnutrition care, significant performance gaps remain in hospitals with respect to malnutrition screening, assessment, intervention, monitoring, and overall care. A 2014 study highlights that while most hospitals report malnutrition screening is taking place within 24 hours of admission, fewer than half were knowledgeable about the 2012 Consensus Statement from the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition (ASPEN) that recommends specific markers and characteristics for diagnosis of malnutrition.^[9] Additionally, several care gaps were identified, including a lack of interdisciplinary clinician participation in the delivery of malnutrition care, inadequate knowledge about or use of nutrition tools, and inadequate training of family caregivers to help treat malnutrition.^[9]

The MQii seeks to make tools and processes available to hospitals to close these gaps in care and knowledge, and potentially improve patient outcomes. **Figure 2** indicates how the MQii is designed to address these gaps by establishing a clear aim to demonstrate an improvement in the quality of malnutrition care at your facility. Reducing variability in clinical practice for malnutrition care is a primary driver for change. By introducing clinical improvements or activities that address each of the change concepts in **Figure 2**, it is anticipated that a facility can reduce clinical practice variability and demonstrate critical improvements in malnutrition care. These changes, in turn, may also improve patient outcomes that potentially lower the cost of care in your facility (see the “Outcomes of Interest” in **Figure 2**).

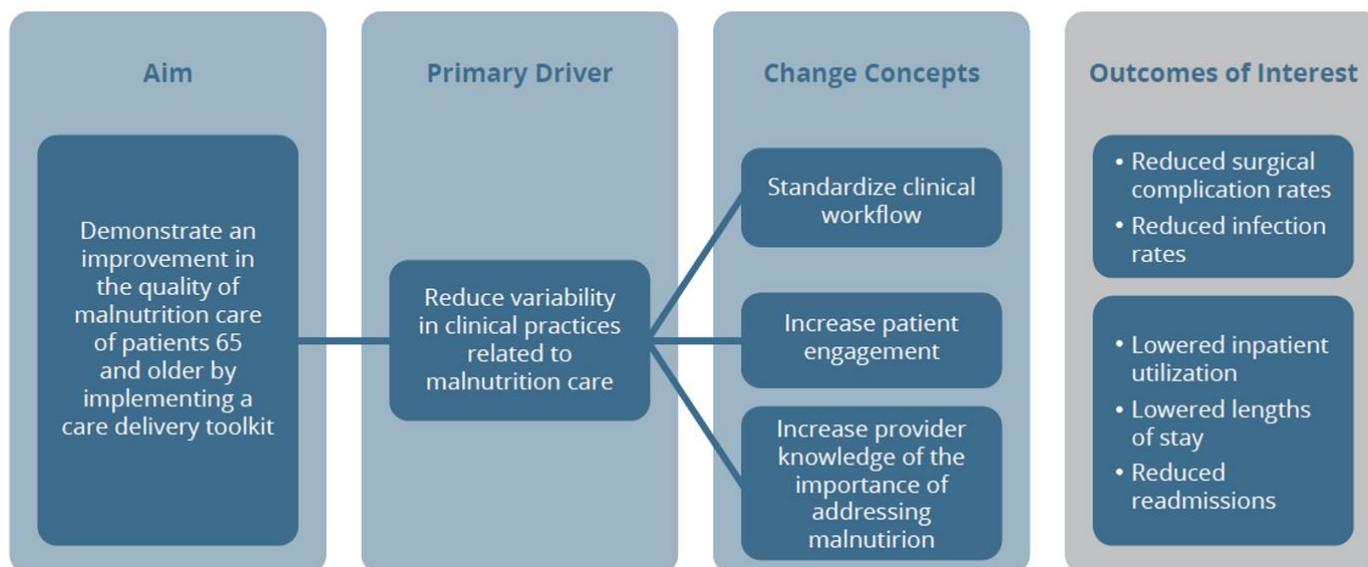


Figure 2: Driver Diagram Illustrating the MQii Theory of Change