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"Never the Twain Shall Meet:" Dual Systems Exacerbate Malnutrition in Older Adults Recently Discharged from Hospitals

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"... and never the twain shall meet."

(Rudyard Kipling, *The Ballad of East and West*)

A MULTI-SYSTEM PROBLEM

There are two parallel but non-intersecting systems providing services to frail older adults: the hospital-based health care system and the community-based social service system. As long as "never the twain shall meet," older adults will continue to suffer the serious consequences of undernutrition, including slower recovery, loss of independence and poorer quality of life, and increased risk of hospital readmission and nursing home placement—all of which contribute to soaring costs of care. This is ironic given today's federal cost containment policy to rebalance long-term care away from nursing homes to home- and community-based services. Today's Affordable Health Care Act (1) places an undeniably robust emphasis on community care given the mandate to cut costs, the majority of which is expended on facility-based care.

The problem begins in hospitals and worsens in communities. Several groups of investigators have documented the lack of coordination between hospital health care providers and community or social service providers. In a large study, hospital discharge planners perceived, rightly or wrongly, that community nutrition services were not readily available even for patients needing those services (2). Unfortunately, this coordination gap can worsen when referrals are made, but there are long waiting lists for nutrition programs in some geographic areas. For example, the Older Americans Act (OAA) Nutrition Program (commonly called Meals-on-Wheels) is not universally available to all frail homebound older adults because of funding shortfalls as well as other related factors such as reliance on volunteers (3). In fact, there has been a substantial decrease in total appropriations for the OAA Nutrition Program in the past two decades ($942 million in FY1990 to $820 million in FY2010), with total meals declining by almost 4 million (4). Congress can and should be

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pushed to rectify the funding shortfall in light of the growing numbers of older adults and the documented increase in hunger and food insecurity among them (5, 6).

A literature review on undernutrition in hospitalized older adults published recently in this journal (7) found that: (1) it is a common and serious problem, (2) hospitalized older adults are at increased risk for it, and (3) undernourished older patients are at risk for experiencing adverse outcomes on discharge. In this commentary, we offer insights into barriers that likely contribute to the persistent underutilization of available nutrition services and consequent gaps in the continuum of care for at-risk recently discharged older adults. The array of community programs available to older adults and their underutilization and/or their underfunding is the focus of a recent position paper by the American Dietetic Association, the American Society for Nutrition, and the Society for Nutrition Education (8).

Continuity of nutrition care is essential for older adults (9). Primary among the barriers that contribute to inadequate transitions of care involve processes that occur both within hospitals and between hospitals and other providers of care. Within hospitals, lower priority is frequently placed on adequately meeting nutritional needs compared with meeting medical needs, which are often viewed as more pressing and relevant to patients' immediate health concerns. A growing body of evidence is accumulating that demonstrates the negative impact that poor transitional care, including non-receipt of nutritional services post-hospital discharge, has on contributing to negative patient outcomes and increased health care utilization and costs (10). It seems that providing up-to-date nutrition education that increases the knowledge of hospital staff who deal with post-discharge planning of older adults is warranted.

Two recent articles by Sahyoun and colleagues in this journal (11, 12) suggest that recently hospital-discharged older adults who are especially vulnerable may be underserved by the OAA Nutrition Program—the nation's largest community nutrition program designed specifically for older adults. Further corroborating this work, an oral presentation delivered this year at the Gerontological Society of America annual meeting reported that such older adults were either not referred or were unwilling to participate in a comprehensive nutrition intervention that potentially included home-delivered meals (a component of the OAA Nutrition Program) (13).

As highlighted in the work by Sahyoun and colleagues, even when six local OAA Nutrition Programs participated in a demonstration project targeted at increasing referrals and enrollment in community nutrition intervention programs, referral of patients from hospitals remained abysmally low. This astonished Nutrition Program staff and investigators who had communicated with discharge planners, administrators, and social workers at the local hospitals and thought that they had their support. Buys and Locher experienced a similar disappointment in their recruitment efforts at both local hospitals and home health agencies. For example, Buys and Locher spent countless hours interacting with the medical director, nurses, and discharge planners in one hospital, including processing all of the institutional review board materials, in hopes of recruiting study volunteers and, yet, did not receive a single referral. In both Sahyoun's and Locher's experiences, daily interaction occurred with partnering hospitals and health care facilities, and the need among patients was high. Yet referrals were low or nonexistent. This is a particularly alarming observation since, in both situations, the services being offered were to be very comprehensive, extending well beyond merely the delivery of meals to homes.

In these two situations, one wonders why health care providers would spend a considerable amount of time establishing relationships with researchers and community partners and agreeing to participate in demonstration projects, but then not follow through by identifying

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potential study participants. Sahyoun and colleagues pointed out that often the bureaucratic roadblocks were ones the hospitals themselves created. Buys and Locher reported encountering similar problems. In some situations, there was uncertainty over who was responsible for making referrals and a lack of support from supervisors in facilitating smooth transitions during times of staff turnover and/or transitions. Frequently, the responsibility falls to social workers, who carry large patient loads and do not focus on nutrition. There are few multi-disciplinary teams and, particularly, the lack of involvement by registered dietitians (RDs), in both hospitals discharge planning and community service provision.

WHAT ARE THE STEPS FOR ADDRESSING THE PROBLEM?

Within the hospital setting as part of discharge planning, appropriate referrals to nutrition services in the community might well be best facilitated by the establishment of routine procedures for doing so. This recommendation is especially relevant as Sahyoun and colleagues pointed out that in one setting, when a single staff member left the project, all referrals to the study stopped. This emphasizes the need for systems to be in place that function in the absence of a solitary individual within an organization.

Sahyoun and colleagues additionally pointed out that policies need to be implemented that incentivize health service providers to make appropriate referrals. As increasing efforts are being directed at linking hospital reimbursement to preventable adverse events following discharge, it is more likely that nutrition-related events will be more carefully scrutinized. Ensuring that patients receive appropriate community nutrition services may be one quality indicator worth examining in the context of the changing health care environment. We are aware of one insurance carrier that demonstrated a cost-benefit in providing meals to recently discharged hospitalized patients (14). Whether it is insurance providers or states that pay for essential nutrition services in communities, this is a logical area to investigate for both improved patient outcomes and cost savings. Increased funding for such initiatives, particularly targeted for short time periods when older adults are recently discharged from hospitals and when they need the services the most, is warranted. In England and some other countries, home-delivered meals and nutrition services are already part of comprehensive cost-containing care following a hospital stay.

We did find in our work that even when patients were offered services, they frequently declined to participate. The primary reasons were that they either (1) did not perceive nutrition as part of medical/health care that would speed their recovery or (2) they were happy with weight loss they had experienced while hospitalized and wished to continue losing weight. Such beliefs were echoed by caregivers and, in some instances, by health care providers. Thus, a major barrier of community program participation involves education of patients, caregivers, and staff regarding the benefits of nutrition services and the harm associated with undernutrition, including weight loss even among overweight older adults. Education efforts should address the multiple and diverse reasons for non-participation (i.e., benefit underestimation, welfare stigma, burdensome application processes, and lack of outreach and program awareness, as well as confusing eligibility requirements) (8).

University curricula and continuing education for nurses, dietitians, social workers, and other health providers can and should encourage collaboration between hospital and community systems. There is a new opportunity for the twain systems to meet as Title VIII in the Affordable Health Care Act and its Community Living Assistance Service & Supports Act (CLASS Act) establishes a new national voluntary insurance program to provide resources to purchase community living services. Undeniably, if we are serious about

helping older adults remain independent in their communities and avoid institutionalization, now is the time for the “twain to meet” (15).

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