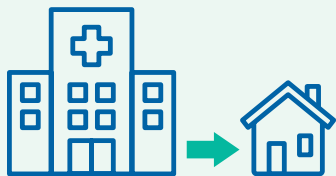


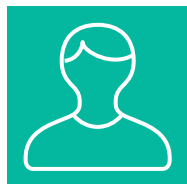
# Discharge Planning and Interventions for Patients with Malnutrition: Improving Patient Outcomes



Up to 40% of hospitalized patients are diagnosed with malnutrition<sup>1</sup> with an average hospital length of stay of 5.4 days<sup>2</sup>. Even with the best of interventions, almost all these patients are discharged with some ongoing malnutrition and need an outpatient nutrition care plan.

The recently approved Global Malnutrition Composite Score (GMCS), a clinical quality measure, includes four main steps of nutrition care: malnutrition screening, assessment, diagnosis, and care plan development which includes needed interventions.<sup>3</sup> Discharge planning for transitions of care should be included in the nutrition care plan and communicating this plan to assure the hospital-based interventions are carried across the healthcare continuum is crucial in order to improve patient outcomes.

## Case 1: When Discharge Awareness is Lacking



This is a 65-year-old man with dehydration and weight loss of 15% of his usual body weight. On admission, he weighed 175 lbs. and complained of abdominal fullness, change in bowel habits, anorexia, and was found to have colon cancer. He

needed to undergo pre-operative nutrition rehabilitation prior to surgery.

In the hospital, he was ordered a soft diet and 4 high-calorie, high-protein oral nutritional supplements (ONS) per day. He was discharged home and scheduled for surgery in 1 month. He returned to the nutrition clinic after 2 weeks and weighed 165 lbs. The multidisciplinary team found the following:

- The patient was discharged prior to being seen by the registered dietitian (RD) for discharge nutrition education.
- The patient was seen by the discharge planner in the hospital, but the ONS order was missed, and the discharge planner was unaware that the patient needed ONS at home.
- The patient did not drive, was very fatigued, and was unable to go to the store to purchase the ONS.
- The patient did not have the funds for ONS, and it was not covered by his insurance.
- He ate only small amounts of regular food and continued to lose weight.
- Due to his declining nutrition status, the surgery was postponed.

### Lessons Learned and Correctional Steps Needed

- Prior to discharge, be sure the patient is seen by the inpatient RD and given nutrition education, including written instructions.
- Arrange for an outpatient RD or nutrition clinic to see this patient within one week of discharge.
- Share the nutrition care plan with the primary provider, discharge planner, outpatient nutrition team, and the patient/family.
- Be sure the patient is seen by a discharge planner to assess insurance coverage and arrange for home health and nutrition care.
- If ONS is not covered by insurance, have the discharge planner or social worker investigate other ways to get support such as coupons and sample kits from manufacturers, food banks and food pharmacies, SNAP, and Medicaid depending on the state and patient diagnosis, and local cancer societies, etc. Also, have the RD instruct on homemade nutritional drinks.
- Inform patient and family that many grocery stores and pharmacies (including online retailers) will deliver ONS to the home.
- Schedule appointments for the patient to see the primary provider and nutrition team as soon as possible.
- Have an Enhanced Recovery After Surgery (ERAS) program see this patient pre-operatively to see how they could provide ONS as rehabilitation.
- Order home health nursing to investigate the home situation within a few days of discharge and evaluate that all orders are being followed.
- Have the patient or family record actual oral intake including volumes of ONS consumed.

## Case 2: When Discharge Planning is Appropriate



This 72-year-old female sustained multiple injuries in a motor vehicle accident. Prior to admission, she was eating normally and in good health. She was admitted to the ICU and placed on a ventilator which put her at risk for compromised nutrient intake.

She began NG tube feedings, but they were not consistently infused, so she received only 65% to 70% of her estimated needs. She received a PEG tube for long-term feedings.

Once off the ventilator, she was able to consume a small amount orally, so continued a high-calorie, high-protein EN formula. The plan was for her to go to a physical rehabilitation facility to continue with physical and occupational therapy prior to returning home.

The discharge planner was notified that the patient would continue EN after discharge to the rehab facility. The RD provided the patient with a nutrition education session to encourage her to consume more nutrient-dense foods orally and provided information about the EN plan of care. EN was cycled at night so she could consume more orally and go to physical therapy during the day. The rehab facility was notified of her specific EN formula and cycling regimen as well as her need for ongoing nutrition assessments.

### Important Steps Taken in Terms of Discharge Planning and Communication

- Early in the hospital stay, nutrition and medical issues contributing to malnutrition were identified.
- Appropriate nutrition therapy with reassessment and adjustment of the therapy continued throughout the patient's hospital stay.
- The discharge planner was consulted to facilitate the patient's transition to a rehab facility.
- The patient/family were educated on nutrition therapy and informed of the rehab facility goals.
- The rehab facility RD was notified of the full nutrition care plan and a follow-up call with rehab facility staff was scheduled.

### Special Issues in Long-term Care (LTC) Transfer and Discharge

- Even if a patient is not going directly home, the RD should review the discharge nutrition intervention and education with the patient and family to make sure they understand the importance of oral nutrition supplements (ONS) or EN.
- Discharge planning information should include the nutrition diagnosis and current plan of care and be sent to the LTC facility so that there is no wasted time with continuing the interventions.
- Communicate the nutrition plan via phone and through transfer paperwork.
- Processes from LTC facility to home should be similar as hospital to home.
- The RD and case manager should evaluate if the patient needs financial assistance or resources to purchase food. Asking important questions about who grocery shops and prepares the meals is vital to determine the home support the patient may need.
- Refer patient to an outpatient clinic for follow-up with the nutrition team so their progress can be monitored and support can be provided after discharge.

### Resources

- **ASPEN Discharge Planning Podcast**  
[nutritioncare.org/DischargePodcast](https://nutritioncare.org/DischargePodcast)
- **ASPEN Malnutrition Care Discharge Checklist**  
[nutritioncare.org/DischargeList](https://nutritioncare.org/DischargeList)
- **MQii Discharge Planning** [malnutritionquality.org/wp-content/uploads/Toolkit\\_Discharge.pdf](https://malnutritionquality.org/wp-content/uploads/Toolkit_Discharge.pdf)
- **Organization Guidelines for Nutrition Support After Discharge**
  - » ESPEN guidelines: [espen.org/guidelines-home/espen-guidelines](https://espen.org/guidelines-home/espen-guidelines)
  - » ASER/POQI Joint Consensus Statement on Nutrition Screening and Therapy Within a Surgical Enhanced Recovery Pathway. *Anesth Analg.* 2018 Jun;126(6):1883-1895.

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2. Centers for Disease Control and Prevention. National health expenditures, average annual percent change, and percent distribution, by type of expenditure: United States, selected years 1960-2019. 2021. <https://www.cdc.gov/nchs/hus/data-finder.htm?&subject=Hospitals>
3. Bechtold ML, Nepple KG, McCauley SM, et al. Interprofessional implementation of the Global Malnutrition Composite Score quality measure. *Nutr Clin Pract.* First published: 11 July 2023 <https://doi.org/10.1002/ncp.11033>

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