March 5, 2014

Ms. Jeanne Serra
Acting Division Director, Division of Regulation and Licensure
Missouri Department of Health and Senior Services
PO Box 570
Jefferson City, MO 65102-0570

Re: Missouri Department of Health and Senior Services Proposed Rule on Food and Nutrition Services (19 CSR 30-20.090)

Dear Ms. Serra:

The Healthcare Nutrition Council (HNC), representing manufacturers of nutrients, supplies and equipment used in the provision of enteral nutrition (EN) therapy, submits these comments in response to the proposed rule issued by the Department of Health and Senior Services/Division of Regulation and Licensure (DHSS) on food and nutrition services (19 CSR 30-20.090).

HNC supports DHSS’ goal of organizing and integrating food and nutrition services in hospitals. HNC applauds DHSS for recognizing the importance of patients’ nutritional health by proposing regulations that require hospitals to screen and assess patients for malnutrition in a timely manner. We believe that these steps are crucial, since the presence or absence of malnutrition is not always obvious. In addition, malnutrition often is associated with acute and chronic diseases and injury. Certain diseases, such as cancer, stroke, and chronic obstructive pulmonary disease may cause a person to be unable to ingest or absorb nutrients, require more energy, or become undernourished due to dietary restrictions. Nutrition status is also associated with the social determinants of health and poor nutrition can be linked to health disparities. Thus, we agree with DHSS that the identification of patients who are malnourished or who are at risk of malnutrition is a critical step in ensuring patients’ nutritional health.

In addition, we recommend that DHSS amend the proposed rule to require hospitals to implement timely, clinically-indicated comprehensive nutrition intervention, including where appropriate enteral nutrition formulas and oral nutrition supplements. As indicated above, malnutrition has significant negative consequences, which also include:

- Increased morbidity and mortality;
- Longer hospitalizations and institutionalizations;
- Increased readmissions; and
- Higher health care costs.¹

Although identifying malnourished patients and patients at risk of malnutrition in a timely manner is an important first step in addressing malnutrition and its adverse effects, the profoundly negative outcomes of malnutrition can be mitigated only if patients receive timely, appropriate clinical nutrition interventions. Such interventions may include diet modification, assistance with ordering and eating meals, or counting patients’ calories. Importantly, oral
nutrition supplements may be medically necessary and clinically effective for some
malnourished patients and patients at risk of malnutrition. However, other patients who are not
able to meet their nutritional requirements orally may require enteral nutrition formulas to be
administered through a nasogastric, gastrostomy or jejunostomy tube. Both oral nutrition
supplements and enteral nutrition formulas help patients effectively prevent and treat chronic
diseases, medical conditions, complications and comorbidities. Thus, if these therapy options are
clinically indicated, we believe that DHSS should require hospitals to implement them in a
timely manner.

In addition, HNC believes that DHSS should encourage the continuity of care by
requiring hospitals to develop comprehensive nutrition care and education plans for patients
post-discharge. Malnutrition impacts patients in all settings. For over 30 years, large-scale
studies have shown that as many as half of hospitalized patients and 35% to 85% of older long-
term care residents are undernourished.2,3,4,5,6,7,8 Malnourished patients and patients at risk of
malnutrition also live in the community.9 Since malnutrition contributes directly to increased
hospital readmissions and other costly negative health outcomes,10,11 we encourage DHSS to
require hospitals to establish nutrition care and education plans for patients being discharged to
all settings including monitoring patients for malnutrition and the risk of malnutrition on an on-
go ing basis.

Thank you for this opportunity to comment on the proposed policy changes on food and
nutrition services. If you have any questions or desire additional information, please contact me
at your convenience.

Sincerely,

[Signature]

Alan K. Parver
Counsel

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1 National Alliance for Infusion Therapy and the American Society for Parenteral and Enteral
Nutrition Public Policy Committee and Board of Directors. Disease-Related Malnutrition and

2 Robinson MK, Trujillo EB, Mogensen KM, et al: Improving nutritional screening of

3 Chima CS, Barco K, Dewitt MLA, et al: Relationship of nutritional status to length of stay,
hospital costs, discharge status of patients hospitalized in the medicine service. J Am Diet Assoc
1997 97:975-978.

5 Braunschweig C, Gomez S, Sheean PM: Impact of declines in nutritional status on outcomes in adult patients hospitalized for more than 7 days. J Am Diet Assoc 2000 100:1316-1322.


Title 19-DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30-Division of Regulation and Licensure
Chapter 20-Hospitals

PROPOSED AMENDMENT

19 CSR 30-20.090 Dietary Food and Nutrition Services in Hospitals. The department is amending the title of the rule, sections (1), (3) through (5), (7), (8), (11) through (14), and the purpose statement.

PURPOSE: This amendment updates language throughout and addresses changes in nutritional screening/assessment requirement time frames. Regulatory citations are also updated.

PURPOSE: This rule specifies the manner in which dietary food and nutrition services shall be organized and integrated in a hospital.

(1) The hospital shall have an full-time employee designated who—

(A) Serves as director of dietary food and nutrition services;

(B) Is responsible for the daily management of the dietary food and nutrition services;

(C) Is qualified by education, training, and experience in food service management and nutrition through an approved course for certification by the Dietary Managers Association or registration by the Commission on Dietetic Registration of the American Dietetic Association, Academy of Nutrition and Dietetics, or an associate degree in dietetics or food systems management; and

(3) The qualified dietitian director shall ensure that a qualified dietitian provides high quality nutritional care is provided to patients in accordance with recognized dietary practices. When the services of a qualified dietitian are used on a part-time or consultant basis, the following services shall be provided on the premises on a regularly scheduled basis as evidenced by the following:

(A) Continuing liaison with the administration, medical staff, and nursing staff; and

(B) Approval of planned, written menus, including modified diets; and

(C) Evaluation and approval of the planned written menus including regular and routine modified diets for nutritional adequacy.

(4) The consultant or part-time dietitian shall assist the director of dietary services or designee shall ensure the following:

(B) Nutritional screening within three (3) days twenty-four (24) hours of inpatient admission to identify patients at nutritional risk. The hospital shall develop criteria to use in conducting the nutritional screening and staff who conduct the screening shall be trained to use the criteria;

(C) Comprehensive nutritional assessments within twenty-four (24) seventy-two (72) hours after screens on patients at nutritional risk, including height, weight, and pertinent laboratory tests;

(E) Participation in committee activities concerned with nutritional care; and,

(F) Planned, written menus for regular and modified diets;

(5) The director of dietary services or his/her designee shall be responsible for—
(A) Representing the dietary food and nutrition service in interdepartmental meetings;

(C) Participating in the selection, orientation, training, scheduling, and supervision of dietary food and nutrition personnel;

(D) Interviewing the patients for food preferences and tolerances and providing appropriate substitutions; Developing a procedure to provide appropriate substitutions or a selective menu for patients with food preferences and/or intolerances;

(F) Scheduling dietary food and nutrition services meetings.

(7) The director of dietary services shall have the authority to be responsible for developing and implementing written policies and procedures governing food and nutrition services and shall have the responsibility for evaluating and monitoring to ensure they are followed. Policies and procedures shall be reviewed at a minimum annually kept current and approved by the chief executive officer or designee.

(8) Dietary food and nutrition services shall be staffed with a sufficient number of qualified personnel.

(11) At least three (3) meals or their equivalent shall be served approximately five (5) hours apart offered with supplementary feeding snacks as necessary. There shall not be more than fourteen (14) hours between a substantial evening meal and breakfast.

(12) Dietary food and nutrition records shall be maintained which include: food specifications and purchase orders; meal count; standardized recipes; menu plans; nutritional evaluation of menus; and minutes of departmental and in service education meetings.

(13) The dietary food and nutrition services shall comply with 19 CSR 20-1.010(19) CSR 20-1.025 Sanitation of Food Service Establishments. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance and shall be attractively served at acceptable temperatures. Potentially hazardous foods shall be served at temperatures specified in 19 CSR 20-1.010(4)(I) and (J), (5)(B), 3 and (11).

(14) When there is a contract to provide dietary food and nutrition services to a hospital, the hospital is responsible for assuring that contractual services comply with rules concerning dietary food and nutrition services in hospitals.


PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Health and Senior Services, Division of Regulation and Licensure, Jeanne Serra, Acting Division Director, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

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