Disease-related Malnutrition

What does it really mean?


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with **Aaron Boysen**, Registered Dietitian, Chief Executive Officer, Primary Care Dietitians

Disease-related malnutrition is often a term that's bandied around within healthcare but what does it actually mean, how often is it actually identified and how is it actually diagnosed? Martha Jackson, Medical Nutrition Manager at BSNA speaks to Aaron Boysen, a Registered Dietitian and Chief Executive Officer of Primary Care Dietitians to hear about his experience.

Hi Aaron, lovely talking to you. For starters, it would be great if you could introduce yourself and tell us about your work to date and how you came to set up Primary Care Dietitians.

I had a few jobs before coming to dietetics, which I came to a little bit later. I've worked in various clinical areas focusing on respiratory, frailty and the ICU to name a few, but I've always been interested in all different areas of dietetics. I have a podcast called 'Dietetics Digest',[1] which was my excuse as a relatively unknown dietitian to talk to those who inspire me. I am also interested in innovation and pushing practice forward to provide better patient care overall, but also how healthcare can utilise dietitians' skills and expertise to provide that better care.

Primary Care Dietitians[2] started because I was working within the NHS and one thing that struck me, and a few of my colleagues, was the lack of support, encouragement and guidance for dietitians in primary care. However, this was not just on the dietitians' side but also within Primary Care Networks (PCN). PCNs are networks of GP practices that never really integrated dietitians fully, or had much experience of working closely with dietitians or how to utilise this service. Dietitians also weren't supported. This issue wasn't just isolated to dietitians. A King's Fund report showed that physiotherapists and pharmacists also experienced similar problems.[3] We met with Primary Care Physio[4] who told us what they were doing. With their help we set out to do the same thing for dietitians, using similar models and processes to provide support and regular supervision sessions, giving structure for dietitians to progress, having dedicated CPD time every week in order to support the PCNs, but also to support the dietitian: it's been really successful. We've grown to a team of 55 dietitians, but we are forecast to have a team of over 60 by the end of the year. Examples of the feedback received from the PCNs are *"we didn't realise the impact the dietitian could have"*, and *"it's revolutionised care in this area"* whether it be in diabetes, frailty, gastroenterology or other conditions.

That's a great introduction and it's interesting to hear how you are supporting dietitians and PCNs. How many PCNs are you involved in and what impact do dietitians have within primary care?

We currently work with around 50 PCNs and are growing every month.

The impact of the dietitian depends on what area they might cover, whether it's diabetes, frailty, paediatrics or cow's milk protein allergy. Roles can also be driven by the targets the PCN may have. But within primary care there are different drivers, so you might have, for example, a practice manager may employ a dietitian to ensure that diabetic patients in their practice go for regular reviews

and get regular support and guidance to help reduce their HbA1c (glycated haemoglobin which shows blood sugar levels). On a broader level, the Clinical Director or PCN Manager who is responsible for providing the Enhanced Health in Care Homes Framework[5] may utilise the dietitian to manage malnutrition and dehydration and other elements that exacerbate frailty. The dietitian might collaborate with local services and be a link to the local dietetic community service to provide that integrated care across different care settings, ultimately improving the patient care journey, which is fundamental.

I also want to touch upon the Roadmap to Practice, First Contact Practitioners and Advanced Practitioners in Primary Care.[6] This gives dietitians the ability to offer more holistic support. I describe it as you take away a little of the dietitian part of you and put in a bit of the primary care practitioner, so you are learning those advanced skills such as ordering tests, conducting examinations, reporting the findings and acting on them appropriately. This obviously needs a lot of support and education, and that's something we help both our PCN and our dietitians with as part of the role.

It's great to hear the positive impact dietitians can have in primary care. You mentioned malnutrition, and as we know malnutrition affects more than 3 million people in the UK most of whom reside in the community.[7] What is your understanding of disease-related malnutrition and what tools are available to screen and assess malnutrition?

As a dietitian, I define disease-related malnutrition as any form of undernutrition resulting from an underlying medical condition. It can stem from reduced intake, impaired absorption, altered metabolism or increased losses.

Regarding screening there are lots of tools available, but even with the most amazing tool I think it is really important to consider the practicalities and the importance of assessing the patient after screening to create an appropriate care plan. The Malnutrition Universal Screening Tool ('MUST')[8] is a good and known screening tool to help identify those patients who are malnourished or at risk of malnutrition. However, I really believe that being able to do a full dietetic assessment, including the patient and their background and possibly using a validated assessment tool such as the PG-SGA©,[9, 10] which is my personal favourite, is important. This allows a more thorough assessment of a patient's nutritional status and being able to examine and evaluate weight loss, body mass index (BMI), disease effects, etc. This is where dietitians can really show their worth.

There is also the Global Leadership Initiative on Malnutrition 'GLIM'[11, 12] which provides criteria to guide the diagnosis of malnutrition and sub-type and in turn, help us determine the most appropriate intervention for the patient.

One thing I would like to highlight when conducting assessments on patients is that it is important to remember different patient groups benefit from different BMIs. For example, based on the 'GLIM' criteria[11] people over 70 should be considered malnourished with a BMI of 20 - 22 kg/m^2 as a higher BMI in certain populations is beneficial for long term outcomes. Delaying action can make it more difficult for the clinician, more difficult for the patient and make interventions more challenging to help prevent and reverse malnutrition.

You mentioned the PG-SGA, what does that stand for?

Patient-Generated Subjective Global Assessment.[9, 10] It uses four patient-generated historical components to generate a number, which I find useful to monitor progress for a patient. I find it easy for patients to understand too, especially as malnutrition is so interlocking with so many areas of our lives that it can feel overwhelming for patients.

Why do you think these tools are not being used effectively and how can dietitians be supported on using the tools, particularly within primary care?

More training is key to ensure dietitians are skilled at properly administering these tools in all settings, including primary care. Additional educational modules or hands-on workshops could help build competency. GPs also need more knowledge on disease-related malnutrition to identify at-risk patients as early as possible.

You mention GPs need more knowledge around disease-related malnutrition. How can dietitians support GPs to ensure malnourished patients or those at risk of malnutrition are identified?

The research[13, 14] and my own experience both show that the level of awareness of malnutrition varies amongst GPs, with a lot of GPs lacking adequate familiarity with disease-related malnutrition and that they often see it as a secondary concern. Dietitians of all levels and bandings can help and be leaders in this area by providing education on screening and assessment, establishing direct referral routes to help patients get the support they need and fostering interdisciplinary collaboration and working together. Our team of dietitians working within primary care as first-contact dietitians do a fantastic job at working with their practices, helping to educate and inform but also support patients, as well as working with local community services to provide that continuity of integrated care.

The nutrition spectrum as a whole, from food first, to oral nutritional supplements (ONS), tube feeds and parenteral nutrition all play a role for patients who need them, and one should not be looked at in isolation from another. What's the most effective way of managing malnutrition?

Screening tools are really useful for identifying patients, but as a dietitian we need to lean on our strengths in providing that more holistic and comprehensive assessment to really tailor the plan to the patient and their individual needs. There are so many factors to consider, for example the support for the patient, financial means, physical mobility, education, cultural background and mental health can all impact nutrition. One-size-fits-all approaches, which seem to prioritise short-term savings over outcomes, do not take into account an individual assessment and plan for that patient. Patients can be managed via food first, using ONS or more advanced interventions like tube feeding if needed. These can be either used in isolation but quite often in combination.

It is important that patients are screened and assessed appropriately and reviewed regularly when it comes to any nutrition intervention. This is easier said than done as we need more dietitians, which will help deliver our long-term plan to help improve nutrition care for patients.

It is always really important to evaluate what we do as dietitians, evaluate our practice and our cost effectiveness, whether that's food first or ONS.

What is your understanding of the current clinical indications for Foods for Special Medical Purposes (FSMPs)?

My understanding is that the Advisory Committee on Borderline Substances (ACBS)[15] provides prescribing guidance on which medical foods can be prescribed to manage specific disease states in the UK. However, I am unsure of the process of how decisions are made. I am aware companies submit the evidence and effectiveness of their product to ensure we have good quality and consistent products on the market to support patients. However, where the product fits in relation to its clinical indication can be challenging as you can't always decide for every single situation exactly, therefore having the guideline is valuable, but you also base your choice of FSMP on the patient in front of you and your clinical assessment.

It's interesting you say you are not aware of the process of the ACBS. Do you feel this may be something dietitians would like to understand more?

Yes, it would be great if there was guidance on how the ACBS operates which explains the process of making their decisions. Understanding this and having this information could help us apply our clinical judgment more appropriately.

Do you feel the ACBS indications are clear enough to those who need to use them? How could these indications be improved to help dietitians and prescribers?

The ACBS indications, or label indications are clear. I think the GLIM criteria[11, 12] helps us quantify malnutrition and it's important to have that diagnosis so that we know what we are treating. However, it's important for a dietitian in practice to assess the patient, use clinical judgment and evaluate the products based on what there is available based on energy, protein, volume etc. Therefore, it's crucial that the dietitian can use their expertise and clinical judgement.

This is what differentiates a dietitian from artificial intelligence (AI), for now. Dietitians can use their clinical judgement to work out a customised plan for a patient based on several factors and we need to remember how important this is. Monitoring and evaluating is where dietitians have the biggest impact because we are experts at troubleshooting and finding solutions to nutritional problems.

And finally, if you went back to being a community dietitian what would you do differently?

Firstly, I would shout louder about the importance of nutrition to clinicians and not assume clinicians' knowledge.

Secondly, I would ensure a standardised way of evaluating the impact of our interventions and adjusting them as time goes on, including looking at various factors in relation to how fast we can solve and prevent malnutrition and what outcomes we are achieving. I would also measure more meaningful indicators. I have found the hand grip and 6-minute walk test are more meaningful to the patient than weight.

I agree that shouting about nutrition and ensuring nutrition is on the agenda is so important. Thank you so much for your time and sharing your experiences with us. Your passion is amazing and it's great to hear all the things you have been involved in.

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