Nutrition “Best Practice” to Reduce Hospital Re-Admissions

Presenter:

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Session Objectives:

After this presentation, the attendee will be able to:

• Know the background and focus of current “best practice” recommendations related to hospital re-admissions.
• Discuss the importance of effective nutritional management related to Value Based Purchasing and Quality Measures.
• Discuss practical application of nutrition “best practice” recommendations in daily practice.
Background Information: OIG Report 2013

- > 825,000 Medicare beneficiaries admitted to hospital from SNFs (> 30% admitted multiple times)
- Approximately 1.3 million admissions
- > $14 billion dollars
- ↑ risks to residents for harm and other negative outcomes

Background Information- OIG Report 2013-Continued

- Hospital admission rates varied based on quality ratings and geography.

  - Source: Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring (Date:11-18-2013)
“Protecting Access to Medicare Act of 2014” (PAMA)

• Enacted April 1, 2014
• Sections 215- added subsections to section 1888 of the Social Security Act for:
  • Quality Measures (QM) for SNFs based on:
    • Rate of hospital readmissions of Medicare beneficiaries discharged to a SNF and a
  • Value Based Purchasing (VBP) program where Medicare payments to SNFs will be adjusted based on their performance scores on the quality measures established.

PAMA: Two Hospital Re-Admission Measures

• All-cause, all-condition hospital readmission measure.
• All-condition, risk-adjusted rate of potentially preventable readmissions.
• Public reporting by October 1, 2017 for the Nursing Home Compare Website.
Value Based Purchasing (VBP)

- Medicare SNF payments will be subject to a 2% withhold starting October 1, 2018.
- Evaluation will be based on ratio of actual readmissions to their expected readmissions relative to the national average.
- Facilities in the bottom 40% will see per diems reduced while those finishing higher will receive full per diem (and may be eligible for a bonus).

**NOW IS THE TIME TO START REVIEWING PROCESSES AND PROTOCOLS RELATED TO HOSPITAL READMISSIONS!!!**

Care Transition is more important than ever!

- New CMS guidelines.
- Emerging payment models.
- Competitive marketplace.
- Focus is on coordinated care for the resident/patient/client.

[Image: http://healthy-transitions-colorado.org/]
CARE TRANSITION IS KEY and NUTRITION plays an important role!

- Hospital to SNF
- SNF to hospital
- SNF to home

NUTRITION

- Focus on prevention and management of malnutrition
- Malnutrition occurs in ALL settings
- Medical Nutrition Therapy (MNT)
- Outcomes: quality of care, costs, quality of life
PREVENTION AND MANAGEMENT OF MALNUTRITION IS VITAL IN ALL SETTINGS

- Acute illness: malnutrition in hospitalized geriatric patients is associated with an increased risk of death at three month
- Post-Hospital Syndrome
- SNF Admission
- Discharge to home

Acute-Hospitalized = Nutritionally Vulnerable

- As of 2013, 14.1% of the population in the US was >65 years, yet accounted for the greatest utilization of healthcare services.
  - 34.9% of all hospital stays
  - greater mean length of stay and cost per stay than any other age group.
- Older adults have a ↑ number predisposing conditions with comorbid illnesses and disabilities = more vulnerable to adverse events during hospitalization.
- Combination of susceptibility and reduced ability to overcome stressors leads to poor long term outcomes and commonly results in loss of independence.
- Decline of all these physiological parameters can potentially be directly related to reduced energy intake.
- When energy intake is insufficient to meet the demands of the body either due to starvation, acute illness or chronic disease/disability, then malnutrition becomes the driver that leads to the further deterioration of functional abilities and inability to recover from disease.
We ARE getting better in Etiology-based malnutrition definitions and diagnosis.


Resource: Alliance Nutrition Care Model

Toolkit: http://malnutrition.com/getinvolved/hospitalnutritiontoolkit
Website: http://malnutrition.com/alliance
Pre- and Post-surgical Concerns Reflect Nutritional Vulnerability

- >1/3 of all surgical procedures are on ages ≥65 years; and has ↑ postoperative complications than for younger patients, resulting in permanent declines in cognitive and physical function
- Poor nutritional status presents an especially high risk situation for older adults undergoing surgery because it:
  - increases the risks for more complications during hospitalization
  - and poor outcomes after discharge related to more infections, poor healing, and increased mortality.

Pre- and Post-surgical Concerns Reflect Nutritional Vulnerability-cont.

- The biggest cause for alarm in older adults after surgery is insufficient action to fully address malnutrition and nutritional risk.
  - Screening for malnutrition in adults admitted into the hospital is conducted 90 % of the time;
  - Known validated screening tools are used only 37.5% of the time.
- Results of a national survey (2012-13) of nutritional screening practices in the US revealed that <40% of those identified to be malnourished actually receive a clinical intervention.
Post Hospital Syndrome

- Transient period of generalized risk for a wide range of adverse events (acquired condition of vulnerability)
- Period of 30 days after discharge from a hospital-risks from stress that occurred from the experience in the hospital along with lingering effects of the acute illness.
  - Sleep deprivation
  - Pain
  - Discomfort
  - Meds
  - NPO
  - ↓ intake food and fluids
  - Restricted therapeutic diets


Hospital-SNF Referral Linkages

Effect of Hospital-SNF Referral Linkages on Readmission

- “Stronger” hospital-SNF linkages were found to reduce readmission rates
- The greater proportion of discharges a hospital sends to a single SNF, the lower the rate of readmission
- Specifically lower rates of immediate bounce-backs (days 0-3)

Rahman et al, December 2013
Nutrition and Care Transitions - Acute

- Coordinate nutrition into discharge planning with acute providers.
- Determine what info is needed and agree on process for proving information: Forms/EHR
  - Current diet order (standardize diet order terminology)
    - Dysphagia – Diet consistency levels? Liquids?
    - Therapeutic diet terminology
    - Liberalization with frail elderly
  - Provide information on overall intake of food and fluids.
- Nutrition Assessment/Recommendations/Discharge
- Share any validated malnutrition risk screening scores.

SNF Nutrition and Care Transitions Systems - cont

- Nutrition screening and referral process
- Process for nutritional “high risk” residents
- Are your weight and heights procedures done according to “best practice” and accurate?
- Focus on “Person Centered Care”
- Liberalize diet to avoid stringent restrictions that may lead to ↓ intake and ↑ risk of illness, infections, and wt. loss.
- Review supplement policies, “real food”, “fortified foods”
- Transitional care plan for nutrition focused on 30 days after admission
- Integrate into QAPI
SNF- Nutrition and Care Transitions-Home - cont.

- Integrate into QAPI
- For SNF to Home: Incorporate nutrition into comprehensive discharge planning.
  - Follow-Up services needed (cooking, grocery shopping, etc.)
- Consider making a Direct Contact after discharge
  - Phone call next day
  - Once a week for a month
  - Once a month for 3 months

Resources/References:

- Alliance to Advance Patient Nutrition Website: [http://malnutrition.com/alliance](http://malnutrition.com/alliance)
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Thank you and Questions 🎓

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