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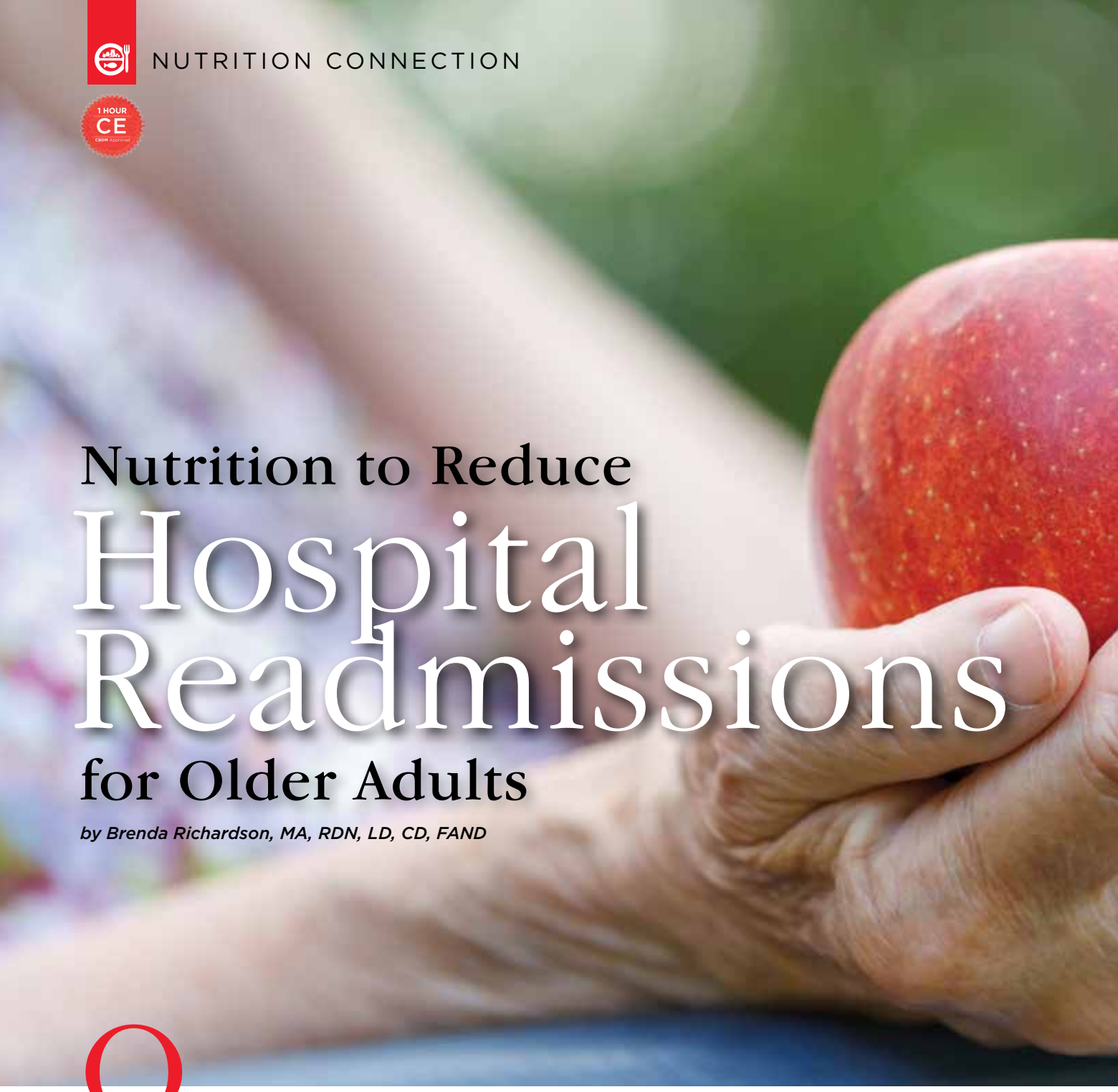

Nutrition to Reduce Hospital Readmissions for Older Adults

by Brenda Richardson, MA, RDN, LD, CD, FAND

Over the past several years there has been continued focus on reducing the number of patients being readmitted to a hospital once they have been discharged. Many factors are involved, and both acute and post-acute providers are paying close attention to reducing their number of readmissions. This not only involves reviews and monitoring of internal systems and processes, but aligning with others to manage care transitions. Food, nutrition, and dining are integral components in overall care transition and significantly impact both quality and financial incentives. This article will look at some of the background information which prompted this focus on reducing hospital readmissions, and will offer practical suggestions for effective care transition management.

In 2013 a report from the Office of the Inspector General (OIG) found that in 2011 more than 825,000 Medicare beneficiaries were admitted from skilled nursing facilities (SNFs) to a hospital, with more than 30 percent of those patients admitted multiple times. This resulted in approximately 1.3 million admissions at a cost of over $14 billion dollars. The hospital admission rates varied significantly based on quality rating and geography. Those facilities receiving more than three stars on the Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare

PRACTICAL SUGGESTIONS FOR EFFECTIVE CARE TRANSITION MANAGEMENT

website had fewer re-hospitalization rates than facilities having three or fewer stars.

The 2013 report not only addressed the costs of hospital readmissions, but the increased risk to residents experiencing harm and other negative care outcomes. Recommendations were made to CMS to develop a Quality Measure for skilled nursing home hospitalization rates, and to include a review of this in the survey process to identify areas of concern.

Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA), enacted on April 1, 2014, added subsections to Section 1888 of the Social Security Act which authorizes new quality measures for skilled nursing facilities (SNFs) based on the rate of hospital readmissions of Medicare beneficiaries discharged to a SNF, and a Value-Based Purchasing (VBP) program in which Medicare payments to SNFs will be adjusted based on their performance scores on the quality measures established.

Two hospital readmission measures currently under development for SNFs will include: an all-cause, all-condition hospital readmission measure, and a measure to reflect the all-condition risk-adjusted rate of potentially preventable readmissions. CMS will provide SNFs with quarterly confidential reports of potentially preventable readmissions beginning October 1, 2016, with public reporting required by October 1, 2017 for the Nursing Home Compare website.

This "value-based purchasing" for skilled nursing facilities Medicare SNF payments will be subject to a 2 percent withhold starting October 1, 2018 (for FY19). As with the hospital readmissions penalty, SNFs will be evaluated on the ratio of their actual readmissions to their expected readmissions relative to the national average. Facilities that perform in the bottom 40 percent will see their per diems reduced, while those finishing higher will receive their full per diem and may even be eligible for a bonus payment.

So now is the time for SNFs to start reviewing their processes and protocols related to hospital re-admissions, even though the reporting and financial penalties are several years away. Since hospitals already receive a penalty for readmissions that occur within 30 days of discharge, they are actively looking to improve care transitions and to work with nursing facilities to lower their hospitalization rates. Knowing that nearly one-fifth of Medicare patients discharged from a hospital develop an acute medical problem within 30 days after discharge which necessitates another hospitalization only adds to reinforcement of successful management of the transition to and from skilled nursing facilities.

NUTRITION'S ROLE IN PREVENTING HOSPITAL READMISSIONS

Nutrition plays a critical role in preventing hospital readmissions, and it's imperative to have initial screening and nutrition interventions in place to enable recovery during care transitions. It's important to remember that older adults are at risk for malnutrition across the care continuum and may become more vulnerable to malnutrition during recovery.

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The prevention and treatment of hospital malnutrition offers a tremendous opportunity to optimize the overall quality of patient care, improve clinical outcomes, and reduce costs. Unfortunately, malnutrition continues to go unrecognized and untreated in many hospitalized patients.

In addition, residents who were recently hospitalized from their acute illness also experience a transient period of generalized risk for a wide range of adverse events. This is referred to as post-hospital syndrome, which is an acquired condition of vulnerability. The period of 30 days after discharge from the hospital has risks from the stress that occurred from the experiences in the hospital, along with the lingering effects of the acute illness that precipitated the hospitalization.

During hospitalization, patients not only endure an acute illness, they also experience additional stress from sleep deprivation, pain, discomfort, medication that may alter cognition and physical function, and become deconditioned from being confined to the bed or being inactive. Nutritional issues during hospitalization may cause problems, yet may receive limited attention. In one study, one-fifth of hospitalized patients 65 years and older had an average nutrient intake of less than 50 percent of their calculated maintenance energy requirements. During hospitalizations, patients commonly receive orders to have nothing by mouth for specified periods, during which they are not fed by alternate means. These deficits are rarely addressed at discharge and can lead to protein-energy malnutrition. Nutrition is coming to the forefront as one of the chief predictors of outcomes.

Post-Hospital Syndrome dramatically increases the risk of a resident being readmitted within 30 days after discharge, often for reasons other than the original diagnosis. It is important for the SNF to recognize post-hospital syndrome along with other factors in development of nutritional screening, comprehensive nutritional assessments, and interventions to promote successful recovery.

A resource that may be helpful for providers in improving nutrition with care transitions is the Alliance to Advance Patient Nutrition, an interdisciplinary consortium launched in 2013 comprised of leaders from the Academy of Medical-Surgical Nurses, the Academy of Nutrition and Dietetics, the Society of Hospital Medicine, and Abbott Nutrition. In addition to the Alliance Nutrition Care Model that was developed, the Alliance to Advance Patient Nutrition has created a downloadable toolkit filled with resources for clinicians including screening tools, feeding tips, fact sheets, case studies, patient discharge materials, and more. Visit http://malnutrition.com/alliance

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RECOMMENDATIONS TO REDUCE RE-HOSPITALIZATION

So what are some areas that SNFs can be working on to improve the care transition and reduce re-hospitalizations related to nutrition?

Some suggested recommendations for residents being admitted to SNF from the hospital include:

- Get re-hospitalization risk information ahead of SNF admissions. Care transitions from acute to post-acute settings require additional risk information than what is currently being provided in simple discharge summaries.

Develop a care transition plan with local hospitals to include discharge planning that incorporates nutrition information.

> Identify nutritional needs (diet order) to allow no lapse in time for adequate nutrition to be provided.

> Standardize terminology for diet orders and supplements with the hospital to decrease confusion during care transitions.

> Develop a protocol and identify specific nutritional information needed.

- Conduct a nutrition screening and referral process for those identified at nutritional risk. Develop a facility protocol of when to refer nutritionally high-risk individuals to the RDN for prompt intervention.
- Consider the impact of Post-Hospital Syndrome in the comprehensive nutritional assessment. Be sure to observe for any signs of malnutrition or dehydration, and follow through with appropriate nutrition interventions.
- Develop a protocol for accurate weight and intake for new admissions from the hospital and readmissions from the hospital. How will you measure? How will you monitor? How do you assess nutrition intervention success?
- Focus on person-centered care and providing food and dining based on their preferences to maximize overall intake and quality of life.
- Liberalize the diet to avoid stringent diet restrictions that may contribute to poor appetite, decreased food intake, increased risk of illness, infection, and weight loss.
- When additional calories or protein are needed try "Real Food" first, prior to initiating nutritional supplements. (Consider fortified foods either at or between meals based on resident preference.)
- Develop a transitional care plan that addresses nutritional needs for the next 30 days after admission.
- Incorporate facility-based nutrition care processes in the Quality Assurance Performance Improvement (QAPI) program.

To reduce re-hospitalizations with residents discharged from SNF to home, it is important to include comprehensive discharge planning. Some areas to address involving nutrition include:

- Review for any appointments needed for follow-up or services needed (cooking, grocery shopping, etc.).
- Review all nutrition-related information with resident, family, caregiver.
- Assess their access to food following discharge. Can they afford food? Do they need assistance from community resources for food?
- Consider making direct contact after SNF discharge:

> Phone call the next day

> Once a week for a month

> Once a month for three months

CONCLUSION

Regardless of your organization's focus, now is the time for SNFs to assess opportunities to coordinate care transitions and reduce readmissions including nutrition best practice. Nutrition plays a critical role in preventing hospital readmissions, and it is important to have specific protocols in place for nutrition/food/dining. Such coordination will help both SNFs and hospitals reduce their exposure to penalties related to readmissions and, more important, will improve outcomes for residents.

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