The Hospital Readmissions Puzzle: Where Does Nutrition Fit?

JOY W. DOUGLAS, PHD, RD, CSG, LD
ASSISTANT PROFESSOR
DEPARTMENT OF HUMAN NUTRITION
THE UNIVERSITY OF ALABAMA

Outline

- CMS Readmissions Programs Overview:
  - Hospital Readmissions Reduction Program (HRRP)
  - Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)
- The Readmission – Nutrition Link
- Strategies for Clinicians

Participant Learning Objectives

- Explain the differences between the Hospital Readmissions Reduction Program and the Skilled Nursing Facility Value-Based Purchasing Program
- Describe the link between hospital readmissions and poor nutritional status
- Generate 2 strategies they can implement in their facility to reduce hospital readmissions

Participant Poll

What type of facility do you work in?
- Hospital
- Nursing Home
- Rehabilitation Facility
- Home Health Agency
- Academia/Research
- Other

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The Hospital Readmissions Reduction Program\(^1,2\)

- Result of the 2010 Affordable Care Act
- Goal: Improve quality of care and save taxpayer dollars by incentivizing providers to reduce excess readmissions
- Links payment to quality of hospital care
- Excess Readmissions = Poor quality of care
- Facilities can lose up to 3% of CMS reimbursement for all Medicare claims

WHAT IS A READMISSION?\(^1,2\)

- Admission to an applicable hospital within 30 days of being discharged with an eligible diagnosis
- Readmission diagnosis and facility can vary

ELIGIBLE DIAGNOSES?\(^1,2\)

- Acute MI
- Heart Failure
- Pneumonia
- COPD
- Elective primary THA or TKA
- CABG surgery

*Includes ICD-9 & -10 codes

What’s an Applicable Hospital?\(^1,2\)

- General, acute care, short-stay hospitals (Subsection D)
- Maryland hospitals participating in the All-Payer Model, although financial penalties are not in place for FY 2018
- Does not include:
  - Long-term care hospitals
  - Children’s hospitals
  - Psychiatric hospitals
  - PPS-exempt cancer hospitals
  - Rehabilitation hospitals and units
  - Critical Access hospitals

How Are 30-Day Readmission Rates Measured?\(^1,2\)

- Over a rolling 3-year period for Medicare beneficiaries: July 1, 2013 – June 30, 2016
- Each hospital receives an Excess Readmissions Ratio (ERR), comparing actual readmissions to predicted ones
  - Lower ratios are better (<1.0); higher are worse (>1.0)
  - Adjusted for case mix and patient risk factors
  - Determine Medicare payments to facilities

See Hospital Compare website: https://www.medicare.gov/hospitalcompare/readmission-reduction-program.html
Participant Poll

How familiar are you with the Skilled Nursing Facility Value-Based Purchasing program?

- Not familiar at all
- Slightly familiar
- Moderately familiar
- Very familiar

The Hospital-SNF Relationship

- 20% of hospital Medicare patients D/C to SNFs
- 2017 Study: The SNF a patient is discharged to is a greater predictor of rehospitalization than the hospital they came from
- The SNF’s operations directly impact their own finances, and those of the hospital
- Hospitals want to discharge patients to SNFs that have low rehospitalization rates establishing preferred provider networks with SNFs to partner in reducing readmissions

The Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

- 2014 Protecting Access to Medicare Act (PAMA)
- Takes effect in FY 2019 – October 1, 2018
- Measures all-cause rehospitalizations from a SNF within 30 days of hospital discharge
- Impacts SNFs paid under the Prospective Payment System (PPS)
- 2% of Medicare reimbursement will be withheld from SNFs and given as incentives for top-performers
- Baseline period: January 1 – December 31, 2015
- Performance period: January 1 – December 31, 2017
- During the performance period, each facility will be compared to:
  - Their own 2015 baseline period = Improvement score
  - Other SNFs during the current period = Performance score
  - Will transition to measuring 30-day potentially preventable readmissions ‘as soon as it is practicable’
Facility Score Reporting
Confidential, quarterly facility updates available in QIES and CASPER

Public Reporting: Nursing Home Compare

What does this have to do with nutrition?
Most Common Readmission Diagnoses

![Bar chart showing 30-day readmission rate for Heart Failure, Heart Attack, and Pneumonia.]

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>30-day Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>25%</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>20%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>18%</td>
</tr>
</tbody>
</table>

*Condition has a direct connection to nutritional status.

Common Causes of Readmission Among Older Adults in Long Term Care

- Lung disease (COPD)*
- Low body weight or low BMI*
- Pressure ulcers*
- Diabetes*
- Cognitive impairment
- Depression
- Swallowing difficulties*
- Presence of a urinary catheter or feeding tube*
- Urinary tract infections*
- Increasing number of medications taken daily*

*Condition/factor has a direct connection to nutritional status.

The Readmission – Nutrition Link: What Does All of This Mean?

- Nutrition is closely related to readmission risk ➔ Malnourished patients have higher readmission rates.8,9
- YOU can help reduce rehospitalizations!

Reducing Readmissions: Strategies for Clinicians

- Establish a Nutrition Support Team
- Designate a Nutrition Champion
- Upon Admission
- During Inpatient/Nursing Home Stay
- Preparing for Discharge
- Appropriate Use of Palliative Care

[Image of a nurse at a desk with medical supplies.]
Establish A Nutrition Support Team

• Interdisciplinary Nutrition Support Teams (NSTs) have been associated with improved nutrition-related outcomes.
• Advocate for the creation of an active interdisciplinary NST for the patients/residents in your facility.
• Include representatives from pharmacy, nursing, the therapies, etc.

Designate A Nutrition Champion

• a 'Nutrition Champion' at the facility to provide increase awareness of the importance of nutrition, and to provide training to other disciplines.
• can be nutrition specialist physicians, dietitians, and/or nurse leaders.
• 'Champions would advocate, model, teach, and reinforce best-practice nutrition.'

Upon Admission

• Aggressively identify and treat malnutrition/undernutrition
• Use evidence-based, validated screening tools
  • Mini Nutritional Assessment (MNA)
  • Malnutrition Screening Tool (MST)
  • Malnutrition Universal Screening Tool (MUST)
  • Nutrition Risk Screening 2002 (NRS-2000)
  • Short Nutritional Assessment Questionnaire (SNAQ)

Study by Sulo et al (2017):
• Nurses screened patients using the MST upon admission
• If score ≥ 2, oral nutrition supplements were automatically ordered in EMR
• Estimated readmissions cost savings of $310,061 for 769 patients ($403 per patient), and reduced hospital length of stay by 0.6 days per patient
During Inpatient/Nursing Home Stay

- Try innovative approaches to improve oral intake
- Hydration Programs
  - To reduce readmissions for dehydration and UTIs
  - Hydration stations with fruit and herb-infused beverages, served in clear dispensers
  - Display in common areas and serve during activities

During Inpatient/Nursing Home Stay

- Try innovative approaches to improve oral intake
  - Appetizing pureed foods
    - To combat poor intake among those with dysphagia
    - Use food molds and piping sets to make food visually appealing
    - One Michigan facility saw unplanned wt. loss decrease from 3.7% to 1.3% after implementing a pureed foods program

During Inpatient/Nursing Home Stay

- Fortified Foods Program
  - To reduce readmissions related to weight loss, anorexia, pressure ulcers, and debility
  - Replace liquid nutrition supplements with fortified menu items
  - Examples: fortified smoothies, ‘super cereal’, fortified mashed potatoes, etc.
  - Will also help to reduce nutrition supplement costs

Preparing for Discharge

- Coordination of Care
- Address food insecurity before discharging patients/residents back into the community
Coordination of Care

• Malnutrition is a risk factor for readmission, so providing for adequate nutrition care after discharge is essential.
• Discharging individuals without planning for how to continue their interventions and plan of care causes fragmented care.
• Fragmented care wastes as much as $25-45 billion annually, and leads to increased readmission rates, complications, and decreased independence and functional ability for patients.
• Fragmented care example: A complicated tube-fed patient with documented intolerances to multiple formulas is transferred to a rehab facility.
  • Rehab facility RD receives no nutrition information about the patient upon admission.
  • Rehab RD then spends 7 days trying various feeding formulas and regimens to find something that the patient can tolerate.

Things to think about:

• Where is this patient going after discharge?
• Are your nutrition interventions appropriate and realistic for the patient to continue after leaving your facility?
• Does the facility they are going to next have a dietitian?
• Can the next facility continue your nutrition care plan?
• Can you communicate with the healthcare team who will be caring for this patient after discharge?

Addressing Food Insecurity

• As of 2010, an estimated 5.6 million older adults either lived below the poverty level, or were considered ‘near poor’ (<125% of the poverty level)
• Food insecurity is associated with hospital admissions
• Greatest risk: older minorities and older females
• Before discharge home, assess whether patients have access to adequate food to meet their needs

Food Insecurity Programs
• Healthy Food Prescriptions
  • MD rx provides vouchers to pay for healthy food options, primarily fruits and vegetables
  • Multiple programs in pilot stages in the U.S.
  • Funded by health systems, or by community agencies
• Medically Tailored Meals
  • Dx-specific meals planned by RDs, delivered to the patient’s home
  • Funded by Medicaid as part of the waiver program
• Nutrition champion: advocate for your facility to participate in programs that connect at-risk patients with community resources to ensure adequate nutrition.
Appropriate Use of Palliative Care\textsuperscript{16,17}

Palliative care is:
• A team-based approach, focusing on improving the patient’s overall quality of life through:
  • Symptom management
  • Clarifying the priorities of the patient
  • Matching treatments to the patient’s goals
• Appropriate for any age and any stage of serious disease
• Compatible with curative treatment, and can be provided at the same time

Palliative care is NOT:
• Limited to those with a life expectancy of < 6 months
• Hospice care
• ‘Giving up’ on a patient; rather, it focuses on identifying and meeting the needs and wishes of the patient

Active palliative care programs are associated with:
• ↑ patient quality of life
• ↑ patient and family satisfaction with care
• ↓ hospital readmission rates
• ↓ health care costs

Without palliative care, older adults with terminal conditions are subjected to:
• ↑ hospital readmissions
• Medical interventions and procedures that ↓ quality of life

Designate a Palliative Care Champion at your facility
• Train staff members on the components and purpose of palliative care
• Educate family members on palliative care
• Use a team approach to clearly define the patient’s goals of care
• Improve communication between the patient, their family members, and the health care team members
• Collaborate with palliative care teams at local hospitals
### References


### References


References


Questions?

Thank You