Transitional Care: Is Your Model Missing a Key Component?

Business White Paper

GA foods

TABLE OF CONTENTS

Health Care Strategies.....4

Transitional Care Models.....5

The Missing Component - Nutrition Care 7

The Economic Benefit of Nutrition Care.....8

Conclusion.....11

References.....13

GA foods™

Nourishment. *Delivered.*

Care transition is the movement of a patient from one health care setting to home or to another health care setting. The most challenging transitions occur when patients are discharged from the hospital to home and community-based services.[1,2]

- Ineffective care transition practices lead to higher hospital readmission rates and costs.[1]
- Approximately 20 percent of Medicare recipients are rehospitalized within 30 days of discharge. [3,4]
- About 75 percent of Medicare readmissions within 30 days are potentially avoidable, costing an estimated $12 billion.[5]

In October 2012, the Hospital Readmissions Reductions Program (HRRP) was launched as part of the Affordable Care Act. It requires Centers for Medicare and Medicaid Services (CMS) to reduce payments to hospitals with excessive readmissions. Per Kaiser Health News, beginning October 2015, nearly 2,600 hospitals will receive lower payments for every Medicare patient. These hospitals lost a combined total of $420 million due to the readmission penalty.[6]

Improving hospital discharge processes and reducing unplanned readmissions have become a priority of CMS. **The purpose of this paper is to review successful transitional care components proven to reduce avoidable readmissions.**

Health Care Strategies

Hospitals have implemented new processes and strategies aimed at improving quality of care to reduce their unplanned readmissions while reducing costs. The strategies include[5]:

- Providing better and safer care during hospitalization
- Reviewing medications with patient prior to discharge
- Assessing discharge planning needs at admission
- Improving communication with patients and families regarding follow-up care
- Improving communication and collaboration with other providers

While these strategies have value, they have shown limited and varying evidence in reducing rehospitalizations;[5] **they do not always prevent breakdowns in communication, patient education, and accountability.**[1]

Transitional Care Models

Addressing the barriers patients experience before, during and after a hospitalization, will help reduce avoidable readmissions. Evidence-based transitional care models that improve the ability of patients and their families to successfully manage care at home have emerged and are being adopted by health care organizations. Project BOOST, Project RED, Transitional Care Model, and Care Transitions are a few of the nationally recognized models with documented success.

Transitional care models target at-risk populations such as the elderly or chronically ill with high health care utilization. **The goal of transitional care is to ensure health care continuity and avoid preventable poor outcomes.**[7] The term, transitional care, is often used interchangeably with other forms of care such as care coordination, case management, and discharge planning, but it is not the same. (See Exhibit 1) Transitional care is complementary to these forms of care.[7]

EXHIBIT 1 - Features of Transitional Versus Other Forms of Care for Chronically Ill Adults[7]

Transitional Care	Primary Care	Care Coordination	Discharge Planning	Disease Mgmt.	Case Management
GOAL					
Ensure health care continuity and avoid poor outcomes	Provide first-care contact	Integrate care across an episode	Offer navigation and safe "medical landing" at hospital discharge.	Slow progression of chronic disease	Link client with resources
TARGET POPULATION					
Highly vulnerable chronically ill	Community-based people	People receiving health or social services	Inpatients	Chronically ill with specific diagnoses	Clients seeking services
SETTING					
Health care exchange points	Outpatient	Across health care settings	In-hospital	Varies	Across health care and human services settings
DURATION					
Time limited	Ongoing	Ongoing	Inpatient episode	Life cycle of disease/condition	Varies based on patient need
FORMAL DISCHARGE					
Yes	No	No	Yes	No	No

Effective transitional care models include these components:

- ***Comprehensive assessment and planning for discharge needs and estimation of readmission risk.***[8,9] Discharge planning begins immediately after admission and includes assessment of self-care needs and care needs provided by family and/or by professionals. Other risk factors such as literacy, recent hospitalization and multiple chronic conditions or medications are also assessed.[1]

- ***Multidisciplinary communication, collaboration and coordination.***[1,9] Direct communication with the primary care provider is encouraged.[8] Hand-offs to other disciplines or settings need to involve verbal communication when possible.[9]

- ***Medication management.*** This includes a plan for obtaining medication after discharge, medication reconciliation, and medication regimen education.[1,8,9]

- ***Timely follow-up, support and coordination after hospitalization.***[1,8] Activities included are scheduling follow-up with primary care provider, home visits and telephonic support, and accompanying the patient to their first follow-up visit.

- **Electronic personal health records.**[9] Personal health records facilitate the accurate transfer of information between care providers and care settings.

- ***Clinician involvement and shared accountability*** during all points of transition.[1,9]

- ***Standardized transition plans, procedures and forms.*** Consists of a written transition plan for patient and family/caregiver that includes active issues, medications, required services, warning signs of worsening condition and who to contact 24/7 in case of emergency.[1] The transition plan also includes education for patient and family/caregiver in the patient's preferred language and literacy level.[1,8,9]

The Missing Component - Nutrition Care

While these transition care models are comprehensive, **all are missing a key component proven to impact patient outcomes– nutrition care.** Nutrition care, in the form of home-delivered meals (HDM) after a hospitalization or as part of chronic disease management, maximizes patient outcomes while reducing health care costs.

After discharge, patients experience symptoms such as decreased energy, pain, weakness, poor appetite and health-related dietary restrictions. These symptoms make preparing and eating nutritious meals difficult. Weight loss and poor nutrient intake can delay the healing and recovery process, resulting in longer, more challenging recoveries, and in many cases, relapse and readmission. Also, at-risk patients (elderly and chronically ill) may have to choose between paying for food or for their medication. **Providing home-delivered post-discharge meals to these at-risk patients has shown impressive results.**

Nutrition care:

- **Promotes faster, more complete recoveries**[10,11]
- **Reduces risk of complications**[11,12]
- **Reduces hospital readmissions**[11-14]
- **Provides crucial support** to patients with poor access to healthy foods[15,16]
- **Improves overall health** and **quality of life**[11]
- Decreases odds of further hospitalizations due to injury[17]
- Enhances management of chronic disease[10,12]

Perhaps more important than these significant outcomes is that an overwhelming majority (92%) of HDM recipients reported these meals allowed them to remain independent and living in their own homes, improving their quality of life.[18] By decreasing their need for shopping and cooking, **HDMs provide a regular source of nutritious food for those that need it for their recovery process.**

The Economic Benefit of Nutrition Care

Malnutrition is one of the greatest contributors to hospitalizations and readmissions. Here are some statistics[19]:

- It is estimated that **one-third of patients are malnourished upon admission** to the hospital
- If left untreated, **approximately two-thirds of these patients will become even more compromised** during their hospitalization
- Roughly **one-third of patients not malnourished at admission will become malnourished** during their hospital stay

Providing access to food allows for the at-risk patients to regain their strength and energy sooner, saving hospitals and health plans money.

One study that evaluated Indiana Medicaid claims found that a greater volume of **HDM services was associated with a lower risk of hospitalization for adults** older than 65 years receiving home and community-based services. The effect of the other two services (attendant care and homemaking) diminished over time, but the effect of HDM did not.[20]

HDM may prevent individuals from using nursing facilities for their post-discharge recovery period. The average cost for a year in a semi-private room in a nursing home is $81,030. **This means that one week in a nursing home is roughly equivalent to one year of home-delivered meals (5 meals per week.)**[18]

MANNA (Metropolitan Area Neighborhood Nutrition Alliance) is a nonprofit organization in Philadelphia that cooks and delivers medically-appropriate meals and provides nutrition counseling to individuals that are chronically ill. Researchers evaluated health care costs of two sample groups, MANNA clients and a comparison group, matched for gender, age, race, and ethnicity, for a 12-month period. Here are the results from their study[10]:

- The total average **monthly health care costs were $28,000 for MANNA clients** and $41,000 for the comparison group.
- The average **cost of a hospitalization was $132,000 for MANNA clients** and $220,000 for the comparison group.
- MANNA clients had **50% less hospitalizations** than the comparison group.
- MANNA clients' length of stay was **37% shorter** than the comparison group.
- MANNA clients were **20% more likely to be discharged from the hospital to their home** rather than to long-term care.

Preventing hospital readmissions by providing HDM for at-risk patients reduces health care expenditures paid by Medicare and/or Medicaid and health plans. **Addressing food insecurity is a strategy that CMS recommends to impact readmissions for diverse populations.** As an example, the risk for avoidable readmissions among minority patients, may be higher, particularly with the existence of chronic conditions in which diet and weight management is essential.[21]

Conclusion

Including nutrition care as a component of transitional care offers better results for both patients and health care stakeholders, including hospitals, integrated health systems and health insurers. Given the proven benefits for all involved, its no surprise that hundreds of U.S. hospitals, many large health systems and a growing number of health insurance plans are implementing and/or approving post-discharge home-delivered meals for the patients they serve.

If you would like more information or to be contacted by member of our healthcare team, please click below:

Request Information

GA foods™

Nourishment. *Delivered.*

GAFoods.com | 800-852-2211

References

[1] Joint Commission. Hot Topics in Health Care. June 27, 2012. Available from: http://www.jointcommission.org/hot_topics_toc/

[2] Spehar AM, et al. Seamless Care: Safe Patient Transitions from Hospital to Home. Available from: http://www.ncbi.nlm.nih.gov/books/NBK20459/

[3] Jencks SF, et al. N Engl J Med. 2009; 360:1418-1428. Available from: http://www.nejm.org/doi/full/10.1056/NEJMsa0803563

[4] Allaudeen, N, et al. J Hosp Med. 2011; 6(2)54-60. Available from: http://www.ncbi.nlm.nih.gov/pubmed/20945293

[5] James, J. Health Affairs: Health Policy Brief. November 12, 2013. Available from: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_102.pdf

[6] Rau, J. Kaiser Health News. August 3, 2015. Available from: http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicares-readmission-penalties/

[7] Naylor MD, et al. Health Affairs. 2011; 30(4):746-754. Available from: http://content.healthaffairs.org/content/30/4/746.full

[8] Weiss, ME, et al. J Nurs Admin. 2015; 45(12):606-614. Available from: http://journals.lww.com/jonajournal/Abstract/2015/12000/A_Model_for_Hospital_Discharge_Preparation__From.6.aspx

[9] Joint Commission. Hot Topics in Health Care. February 19, 2013. Available from: http://www.jointcommission.org/assets/1/6/TOC_Hot_Topics.pdf

[10] Gurvey J, et al. J of Prim Care & Comm Health. 2013; 4(4):311-317. Available from: http://jpc.sagepub.com/content/4/4/311

[11] Tappenden KA, et al. J Parenter Enteral Nutr. 2013;37:482-497. Available from: http://www.sciencedirect.com/science/article/pii/S2212267213006412

[12] Vesely R, Hospitals & Health Networks. March 11, 2014. Available from: http://www.hhnmag.com/articles/4831-hospitals-put-nutrition-on-the-front-burner

[13] Mudge, AM, et al. J Hosp Med. 2011:6(2)61-67. Available from: http://onlinelibrary.wiley.com/doi/10.1002/jhm.811/full

[14] FMQAI, Florida's Medicare Quality Improvement Organization under contract with CMS.

[15] Seligman HK, et al. Health Affairs 2014; 33(1):116-123. Available from: http://www.aspeninstitute.org/sites/default/files/content/docs/ee/Seligman%20Health%20Affairs%202014%20Health%20Affairs.pdf

[16] Thomas KS, et al. Health Affairs 2013; 32(10):1796-1802. Available from: http://content.healthaffairs.org/content/32/10/1796.abstract

[17] Neelemaat F, et al. J Am Med Dir. 2011;12(4):295-301. Available from: http://www.ncbi.nlm.nih.gov/pubmed/21527171

[18] Sahyoun NR, et al. J Parenteral Enteral Nutr. 2014;29(4):459-465. Available from: http://ncp.sagepub.com/content/29/4/459.abstract

[19] Barker, LA. et al. Int J Environ Res Public Health. 2011; 8(2):514-527. Available from: http://www.mdpi.com/1660-4601/8/2/514

[20] Xu H, et al. J Am Geriatr Soc. 2010:58(1):109-115. Available from: http://www.ncbi.nlm.nih.gov/pubmed/20002513

[21] Betancourt JR, et al. Centers for Medicare & Medicaid Services Office of Minority Health. Sept 2015. Available from: https://www.cms.gov/About-CMS/Agency-information/OMH/Downloads/OMH_Readmissions_Guide.pdf