Healthcare Nutrition Council

529 14th Street, NW • Suite 750 • Washington, DC 20045

The Honorable Kenneth LaValle
Chairman
Committee on Higher Education
New York State Senate
188 State Street
Legislative Office Building Room 806
Albany, NY 12247

The Honorable Toby Ann Stavisky
Ranking Member
Committee on Higher Education
New York State Senate
188 State Street
Legislative Office Building Room 706

RE: HNC Support for New York Senate Bill 2628 – Qualified Dietetic Professional

Dear Senators LaValle and Stavisky:

The Healthcare Nutrition Council (HNC), representing manufacturers of enteral formulas, parenteral solutions, supplies, and equipment, wishes to express our strong support for New York Senate Bill 2628, which would allow a qualified dietetic professional or qualified nutrition professional to manage the diet of patients being treated in a facility by a physician for specific diseases. HNC supports this bill as we believe it will increase screening, diagnosis and treatment of malnourished patients and provide greater patient access to vital therapeutic nutritional products under the appropriate professional oversight.

As explained in detail below, higher rates of nutrition screening and treatment combined with greater access to therapeutic nutrition products will improve patient outcomes and are likely to reduce healthcare costs in the state. Because this legislation will have an immediate positive impact on patients, we actively support SB. 2628, encourage its speedy consideration in the Senate Committee on Higher Education, and call on you and other members of the Committee to help build momentum for the eventual enactment of the bill into law.

Registered Dietitian Nutritionist Are Uniquely Qualified to Order Therapeutic Nutrition Interventions

Registered Dietitian Nutritionist (RDNs) are highly trained in the area of clinical nutrition and are often in the best position to assess a patient's nutritional status. They are often the most qualified to work with other providers to implement a nutrition plan, including ordering therapeutic nutritional products when the results of a nutrition screening or assessment indicates such products are indicated. RDNs who maintain an active license and current certification, have met the New York requirements specified in statute and have specific training in enteral and parenteral nutritional therapies are uniquely qualified to evaluate a patient's nutritional status and work with the medical team to render a diagnosis and recommend nutrition interventions that will be effective for treating the patient's specific medical condition(s) or chronic disease(s).

Furthermore, we note that this bill is consistent with a 2014 Final Rule published by the Centers for Medicare and Medicaid Services (CMS) which, among other things, allows a physician in hospitals and long-term care setting to delegate the ability to order therapeutic diets to RDNs when allowed by state law.[i] The passage of SB. 2628 would also help New York join 18 other states where there are no statutory or regulatory impediments to RDNs receiving hospital privileges to order and manage therapeutic diets to a patient.[ii] Given the potential positive impact on patient access to essential therapies that can improve

health outcomes and reduce costs of care, HNC actively supports ongoing efforts by the Academy of Nutrition and Dietetics to remove existing impediments to these qualified RDNs to provide dietary orders.

Nutritional Status and Its Impact on Patient Outcomes and Healthcare Costs
It is widely recognized that nutritional status plays a significant role in health outcomes and healthcare costs. Data also shows that malnutrition is widely underdiagnosed and often goes untreated. In a recent study conducted by the Agency for Healthcare Research and Quality using the Healthcare Cost and Utilization Project database, only about 7 percent of hospitalized patients are diagnosed with malnutrition.[iii] Yet, for over 30 years, large-scale studies have shown that as many as half of hospitalized patients and 35% to 85% of older long-term care residents are undernourished or at risk of becoming malnourished.[iv,v,vi,vii,viii,ix,x] This diagnosis gap is of great concerns and offers an opportunity for improvement which RDNs are uniquely qualified to address.

Malnutrition often is associated with acute and chronic diseases and injury, such as cancer, stroke, chronic obstructive pulmonary disease, heart failure, infection, trauma and surgical procedures. These diseases and conditions may cause an individual to become malnourished or may be exacerbated in a malnourished patient. Overall patient care and outcome are affected by nutrition care management, which includes timely diagnosis and application of appropriate treatment of malnutrition. Giving RDNs clear authority to order and manage therapeutic nutrition when indicated will have a direct and immediate impact on patient outcomes that are influenced by nutritional status.

A 2014 study estimates that the annual burden of disease-related malnutrition for older adults aged 65 years and older across eight diseases was $51.3 billion.[xi] The authors hypothesize that their findings likely underestimate the total burden of disease-related malnutrition since its rates are much higher in hospitalized patients.[xii] Furthermore, malnourished patients and patients with nutrition related or metabolic issues are frequently readmitted to the hospital, which impacts overall healthcare costs for such patients.[xiii, xiv] Studies have demonstrated that readmissions are 24-55% more costly than initial admissions and account for 25 percent of Medicare expenditures.[xvxvi] Data from 2013 showed that 30-day hospital readmission rates for all causes (other than maternal or neonatal) to be more than 50 percent higher for patients with malnutrition. Rates of readmission were found to be highest among adults aged 18-64 years, those paid by Medicaid and those residing in metropolitan areas. Further, the average costs per readmission for patients with malnutrition were found to be 26-34 percent higher ($16,900 to $17,900) for patients with malnutrition compared to those without malnutrition ($13,400).[xvii]

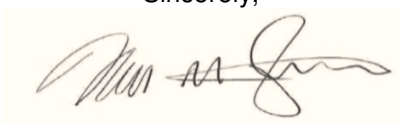
Timely, appropriate clinical nutrition therapies provided by RDNs can improve or maintain patients' nutritional status, resulting in less morbidity and fewer complications, shorter hospital stays, fewer hospitalizations, reduced hospital readmissions and increased savings. For these reasons, HNC sees the real potential for SB. 2628 to, most importantly, improve patient outcomes by increasing diagnosis and treatment by RDNs of malnutrition, but to also reduce healthcare costs associated with untreated malnutrition.

Conclusion
Detecting risk factors and accurately diagnosing malnutrition can be done easily by routinely having RDNs screen patients for malnutrition and provide patients with timely, follow-up assessments, if needed. Once a diagnosis is determined, and if further nutritional intervention is indicated, these qualified individuals must have the authority to order and apply appropriate nutrition therapies, including oral nutrition supplements, enteral or parenteral nutrition, and nutrition-related services.

For all of these reasons, we strongly support SB. 2628, encourage speedy consideration of the bill in the Senate Committee on Higher Education and hope enough momentum can be generated to ensure its eventual enactment into law.

Thank you for the opportunity to comment on this important legislation. If you have any questions or would like additional information, please contact me at ngardner@kellencompany.com or 202-207-1116.

Sincerely,



Nicholas Gardner
Executive Director
Healthcare Nutrition Council

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