Infusion Therapy: A Comprehensive Approach to Census Development, Reducing Avoidable Rehospitalization, and Revenue Enhancement

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Objectives

• Review FY 2013 reimbursement rates for infusion-related RUGs categories and compare with 2012 rates
• Present case studies for residents receiving parenteral nutrition, antibiotic and inotropic therapy
• Discuss the potential impact of the Affordable Care Act on LTC including:
  – Accountable Care Organizations (ACO)
  – Hospital Readmission Reduction Program (HRRP)
• Develop admission strategies to ensure quality management and successful outcomes for the resident admitted with infusion therapy needs

Facilities must be prepared to accept residents with high acuity/clinical complexity to remain economically viable and relevant to post-acute care

Infusion Therapy is a key component in the care of an increasingly complex resident
Industry Drivers

• RUGs IV
  – Revenue neutral, but shifts funds from rehab categories to medically/clinically complex categories

• The Patient Protection and Affordable Care Act-PPACA
  – The Hospital Readmissions Reduction Program-2012
    • Acute Care Providers penalized for preventable rehospitalizations
    • Diagnoses (CHF-Pneumonia-Acute MI)
  – Accountable Care Organizations (ACO)
    • Integrated Healthcare-Shared Risk and Shared Savings

RUGs Category Rates
FY-2012 versus FY-2013

• In the August 2nd, 2012 publication of the Federal Register, CMS released the RUG rates for FY-2013

• As expected, the new rates represent a 1.8% increase over FY-2012 rates
  – Infusion related RUGs increase by 1.83%

• Before looking at rates for 2013, let’s review what happened in 2012

CMS Cut Rehab RUGs by 12%-19%
While IV RUGs Increased by 1.5% in FY-12
Infusion Related RUGs Categories
Rates for FY-2013

Skilled Medicare Infusion Therapy
RUGs-IV Categories

- TPN-Special Care High (HC, HD, HE)
  - Federal Urban Rates $341-462 depending on end splits for depression and ADLs

- IV Medications-Clinically Complex (CB, CC, CD, CE)
  - Federal Urban Rates $266-374 depending on end splits for depression and ADLs

Importance of Infusion Therapy to Skilled Facilities

Infusion Therapy is a key component in the care of an increasingly complex resident

- Skilled Facilities must be prepared to accept residents with high acuity/clinical complexity to remain economically viable and relevant to post-acute care

- Some SNFs may not consider admitting infusion residents due to drug cost or the clinical patient care required

- Let’s review three case studies to determine how admitting a resident with infusion therapy may affect your facility

SNF Perceptions about TPN

- Many customers remember the days when the cost of TPN was $400, $500, up to $800 per day
  - Most common TPN formulas are well below $300 per day
  - Depending on additives they range from $150-$250

- Many nurses believe that caring for a resident receiving TPN is very complicated
  - Keep in mind that TPN is food; it is never a life-saving medication that must be delivered stat
  - Given the proper education, clinical nursing policies, clinical tools, and a good Infusion Pharmacy for support: a TPN resident is no more difficult to care for than a resident receiving Vancomycin
**TPN—Total Parenteral Nutrition**

**Example #2**

Your facility receives a referral to admit a resident with a history of ETOH abuse, cirrhosis, depression, diabetes, and pancreatitis. The resident requires skilled care for 3–4 weeks of TPN therapy to "rest the gut". The RUGs category is Special Care High HD2 due to symptoms of depression and an ADL score of 11. The resident receives TPN for 21 days but remains skilled for 30 days.

- **Approximate HD2 per diem rate** = $433
- **Approximate Costs**
  - $200 per day plus TPN at $150 per day
  - (Days 1-21) $350 X 21 days = $7,350 Cost of care
  - (Days 22-30) $200 X 9 days = $1,800 Cost of care
- **Total Medicare Payment** = $12,990
- **Total Estimated Cost** = $9,150
- **$12,990 - $9,150 = $3,840 additional payment due to IV nutrition**

**IV Vancomycin**

**Example #1**

Your facility receives a referral for a patient with MRSA (post-op wound). Orders: Vancomycin 1 gram IV every 24 hours x 14 days via PICC. The resident's ADL score is 11 and the resident exhibits symptoms of depression. The RUGs category is Clinically Complex in the CD2 group. The resident remains skilled for 30 days.

- **Approximate CD2 per diem rate** = $354
- **Approximate Costs**
  - $180 per day plus IV med at $70 per day
  - (Days 1-14) $250 X 14 days = $3,500 Cost of care
  - (Days 14-30) $180 X 16 days = $2,880 Cost of care
- **Total Medicare Payment** = $10,620
- **Total Estimated Cost** = $6,380
- **$10,620 - $6,380 = $4,240 additional payment due to IV antibiotic**

**IV Primacor**

**Example #3**

Your facility receives a referral for a resident with end stage CHF & deconditioning. MD orders Primacor 0.5mcg/kg/min X 8 hours Mon–Wed–Fri. The resident’s weight is 70kg. The resident’s ADL score is 11 and the resident exhibits symptoms of depression. The RUGs category is Clinically Complex in the CD2 group. The resident remains skilled for 30 days.

- **Approximate CD2 per diem rate** = $354
- **Approximate Costs**
  - $180 per day plus IV med at $72 per day
  - (Days 1-14) $252 X 30 days = $7,560 Cost of care
- **Total Medicare Payment** = $10,628
- **Total Estimated Cost** = $7,560
- **$10,628 - $7,560 = $3,068 additional payment due to IV antibiotic**
Impact on LTC:
Accountable Care Organizations
- The final rule establishes quality performance measures and a methodology for linking quality and financial performance that will set a high bar on delivering coordinated and patient-centered care by ACOs, and emphasize continuous improvement around the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures.
- The final rule requires ACOs to publicly report certain aspects of their performance and operations and CMS to publicly report certain quality data.
- Accountable care organizations are designed to incentivize healthcare providers by allowing them to share in savings resulting from better, less expensive care.
- "Any ACO that is going to be successful has to be proactive in providing care for those patients in a post-acute setting to avoid necessary rehospitalizations," according to CMS deputy administrator Jonathan Blum.

Accountable Care Organizations
- Integrated Healthcare
- Shared Risk
- Shared Savings

ACA Hospital Readmissions Reduction Program
- On October 1, 2012 payments to hospitals were reduced for excess readmissions of patients with certain conditions:
  - Pneumonia
  - CHF
  - Acute MI
- A total of 2,217 hospitals are being penalized in the first year of the program.
- Of those, 307 will receive the maximum penalty: 1 percent of their regular Medicare reimbursements.
- Medicare has estimated it will recoup about $280 million from hospitals where it determined too many heart attack, heart failure or pneumonia patients readmitted within 30 days.
- October 1, 2013 the penalties increase to 2%.
Where Are We Now?
Hospital Readmission Rates Plateau Provide SNFs with Opportunity

- Penalties for preventable hospital readmissions began on Oct 1, 2012. A study released one month before the penalties were imposed revealed data that demonstrates U.S. hospitals aren’t making much progress in lowering readmission rates
- While this is not great news for hospitals, it presents an opportunity for post acute providers
- Medicare’s Hospital Compare website*
  - Readmission rates for heart failure were 24.7% for years spanning July 2008 to June 2011, a decrease of 0.1% from the previous year’s numbers
  - Readmissions for pneumonia grew 0.1% to 18.5% of all Medicare pneumonia patients, from 2010 to 2011*

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Why Rehospitalize?

- It can be a tough decision – to send out or not
Why are Rehospitalization Rates So High in SNFs?

• Nurses are likely to hospitalize a resident when:
  – the resident has fallen
  – has an infection
  – is disruptive or violent
• Lack of education to care for high acuity residents
• Inability to identify changes of condition early, before they require a rehospitalization
• Lack of nursing resources to manage all of the extra duties that may be required (e.g., collecting specimens, starting and monitoring IVs)
• Nursing may not have the skills to communicate a physical assessment and history to an off-site, on-call physician
• Physicians may not know the facility’s capabilities or trust the facility to manage complex clinical conditions

Where to start?

• Collect & analyze data on rehospitalization rates
• Determine causative factors
• Design programs to reduce hospital readmissions
• Develop programs to ensure staff capability to accept higher acuity residents and manage the complications that occur in this population

What should I focus on?

• 78% of all preventable, 30-day rehospitalizations in SNFs are due to:
  • Electrolyte imbalances
  • Respiratory infections
  • Congestive heart failure
  • Urinary tract infections
  • Sepsis
It can be a tough decision – to send out or not

Where to start?

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- Allow marketing/admissions/rehospitalization rates data to drive clinical programming

Pre-admission Assessment

- What is the projected RUG score?
- Will the resident receive IVs? Hydration? TPN or PPN? IV medications?
- If IVs, do they have the appropriate catheter to administer the therapy?
- Are there other diagnostic/monitoring associated costs that should be considered?
- Is the therapy prescribed uncommon?
- Has the nursing staff administered/provided care for this type of therapy in the past?
- Is education available for all staff prior to admission?
- Are drugs/supplies/services available?
- Are policies and procedures in place to care for the needs of the complex resident?
- Are Advance Directives in place?
Admitting the Infusion Resident

The expert management of your residents’ infusion needs during the admission process is critical to successful outcomes.

How can this affect your facility’s bottom line?
Let’s take a look at Mr. Jones:

Mr. Jones (Demographics)

Mr. Jones is a 93 year-old admitted to acute care from home where he was living with Mrs. Jones, his 91 year old wife and caretaker.
History

• Mr. Jones has a diagnosis of middle stage dementia. The admission note states he is pleasantly confused and forgetful. He was in a quiet private room at the end of the hallway in acute care. He was also on Ativan during his hospital stay because of his diagnosis of dementia. He is being admitted to your facility because he cultured positive for MRSA and needs 3 more weeks of IV ABX.

He arrives at 5:30pm on Friday evening. His admission paperwork states he has an IV but does not clarify the type of line. His next dose of Vancomycin is due at 6:00pm. He has not received any of his other meds since 8am (including his Ativan, which was d/c’d anyway because we don’t use anxiolytics in LTC).

The nurse, who is in the middle of her 5pm med pass, quickly assesses Mr. Jones and notes he has an IV catheter above his left antecubital fossa.
Because there is no documentation regarding the IV, the nurse must call the hospital to get more information. At 5:30 on Friday night she is told the chart is in route to medical records. The other nurses on duty at the hospital did not care for Mr. Jones and are unable to help with the IV catheter information.

The impact on the facility:
- The nurse must call the MD for an order for a CXR to verify line placement
- The nurse must start a short peripheral IV catheter to administer the 6pm dose
- Once the CXR is read the nurse may safely use the line

But the plot thickens…
Mr. Jones is put in a room with a resident who is noisy and bangs on his bedside table throughout the night. Mr. Jones has not received his Ativan since 8am that morning. He is in a new, strange environment and is becoming increasingly agitated with all the noise. He pulls out his VAD and hands it to the nurse the next time she enters the room.
The impact on the resident:

Because there is no documentation regarding the length of the catheter, the nurse is not certain that Mr. Jones has not left a piece of the catheter in him. Mr. Jones must be sent back to the hospital to determine if he has a catheter embolism.

Impact on facility:

- Failed admission
- Poor outcome for the resident
- If resident is readmitted, facility must pay for new catheter placement
- Negative feedback from referral source
- Nursing time cost $$$

Gather Information BEFORE the Resident is Discharged!

- Reduce negative economic impact
- Improve quality of care
- Decrease unnecessary rehospitalization
- Stabilize census
Healthcare Reform Impact on LTC

- Long-term care providers must collaborate and create partnerships with their acute care counterparts in order to make efficient use of new technology.
- In the short term, long-term care providers have to strengthen relationships and then become a part of accountable care organizations and other bundled payment initiatives.
- “It's important that you raise your hand with accountable care organizations and you raise your hand with your admission sources so that you can engage in what information they need, and information you need.”

Ref: Deborah Green, Vice President of HIM solutions at the American Health Information Management Association (AHIMA), August 8th, 2012

Clinical Liaison Education/Support

- Admission/Marketing associates need infusion education
  - General knowledge of infusion therapies
  - Appropriate IV catheters for the therapies
- IV assessment should be included in preadmission process

Vascular Access Device Pre-Admission Assessment

- Type of device
  - Short peripheral
  - MIDline
  - PICC (peripherally inserted central catheter)
  - Non-tunneled
  - Tunneled
  - Implanted port
- Date of insertion
- Insertion site
- Gauge and Size
- Brand and lot number
- Number of lumens
- All Central Vascular Access Devices
  - Written verification of tip placement
Preadmission Assessment

Economic Considerations:
• RUG Classification Information:
  • Will the resident receive IV Hydration, TPN or PPN? RUGs rate?
  • Will the resident receive IV medications? RUGs rate?
• What is the approximate cost of drug/solution?
• What is the approximate cost of infusion supplies?
• Are there other diagnostic/monitoring associated costs that should be considered?

Clinical Considerations
• Has the nursing staff administered this therapy in the past?
• Is the route and method of administration approved for use?
• Is the IV therapy ordered a vein irritant or vesicant?
• Does the resident have the appropriate vascular access device (VAD) in place prior to admission to the SNF?
• Will the referring facility place an appropriate VAD prior to resident transfer?
• Does the resident have restrictions on where the access may be placed (e.g., dialysis fistula/catheter, mastectomy, stroke, etc.)?

Advanced Clinical Programming
• Allows you to admit clinically complex residents
• Permits opportunities to partner with referral sources
• Decreases unnecessary rehospitalizations
• Increases opportunities for inclusion to ACOs and Bundled Payment Initiatives
Advanced Therapies

Parenteral Nutrition

- TPN – Total Parenteral Nutrition
- PPN – Peripheral (Partial) Parenteral Nutrition

Referral sources:
- Discharge planners
- Hospitalist groups
- Surgeons
- Bariatric centers
- Gastroenterologists
- Oncologists

**Reminder: Hydration does not provide Nutrition**

Advanced Therapies

Inotropic Therapy

- Provides a solution to hospital partners
- Provides quality of care for end stage heart failure residents

Referral sources
- Discharge planners
- Hospitalist groups
- Cardiologists
- Internal Medicine/Family Practice Physicians

Advanced Therapies

Patient Controlled Analgesia

- Allows you to keep residents in place when IV pain management is required
- Hospice partnerships

Referral sources
- Discharge planners
- Hospitalist groups
- Cardiologists
- Internal Medicine/Family Practice Physicians
Advanced Therapies

IV Push Medication Administration

- Diuretics:
  - Management of fluid volume overload

- Corticosteroids:
  - Management of muscular dystrophy, respiratory diseases, other autoimmune diseases

If You Build It They Will Come

.... or will they?

Promoting Your Capabilities

- Sample Announcement Letter
- Marketing Brochures
  - Target discharge planners
  - Demonstrate your commitment to ease the discharge process for clinically complex infusion patients
  - Describe your partnership with your infusion pharmacy

Who You Should Target When Marketing Infusion Therapy

- Discharge planners, Case Managers, Social Workers
- Hospitalist Groups (all therapies)
- Internal Medicine/Family Practice physicians (all therapies)
- Infectious Disease physicians (antibiotics, antivirals, antifungals)
- Surgeons (antibiotics, pain management, TPN)
- Bariatric surgeons (TPN, hydration)
- Cardiologists (inotropic therapy, i.e., Dobutamine, Milrinone-meds for chronic CHF patients)
- Gastroenterologists (TPN, hydration, antibiotics)
- Orthopedic surgeons (antibiotics, TPN)
- LTACs (all therapies)
- Oncologists (chemotherapy, hydration, pain management)
Additional Ideas

- Home Health
- Emergency Room
- Medical Directors
- Discharge Planners

Advantages of Accepting Residents with Infusion Needs

- IV therapy RUG rates are favorable for infusion related therapies
- May reduce costly unplanned hospital transfers
- Higher census with fewer empty beds
- Can provide opportunities to build relationships with key referral sources
- May put you in a better position to partner with hospitals for ACO inclusion
- Allows you to re-admit your own residents versus transferring the resident to a competitor
- Allows you to admit the higher acuity infusion resident that your competition refuses to take

QUESTIONS ?