



NAVIGATING THE PDPM TRANSITION

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Providers will soon be eligible for higher reimbursements for infusion therapy services.



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Training and planning are critical to building the right system for attracting new partners and patients.



SUCCESSING IN AN ERA OF MAJOR TRANSITION

Nursing home providers can't afford not to keep up on important issues and expect to survive, yet alone thrive, under the Patient-Driven Payment Model (PDPM). Some of the most significant topics include infusion therapy, admission medication regimen reviews and education.

Boosting an existing infusion therapy program, or starting a new one, requires a focused plan, education and skill to assure success.

In the new PDPM era, providers must get it all right — and right from the start. That's why admission medication reviews are so important. We oversee 600,000 of them annually and can guide you through that world. Eliminating unnecessary medications and treatments can improve resident safety and lower cost while enhancing clinical value and reducing readmissions to the hospital.

Education on a variety of clinical care topics is vital to operator success. Under PDPM, providers must thoroughly understand these subjects to stay vital in their respective surroundings.

PDPM is here and it's time for providers to rise and embrace the opportunity to succeed.

Nancy Losben
R.Ph., CCP, FASCP, CG

Senior Director, Quality
Omnicare, a CVS Health Company

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EXPANDING YOUR SERVICES: DON'T LET PROSPECTS DRIP AWAY

AN INFUSION THERAPY PROGRAM CAN REAP MORE BENEFITS

By Kimberly Marselas

Long-term care residents are prescribed infusion therapies every day in skilled nursing facilities across the nation.

But an infusion program that goes beyond providing basic IV hydration and antibiotics will equip facilities to handle residents with more complex needs, whether that means total parenteral nutrition (TPN) or inotropic therapy, patient-controlled analgesia or blood and blood products.

“We’ve been providing infusion therapy in the skilled nursing facility setting for many years,” said Corinne Bishop, RN, CRRN, CRNI, National Leader, Infusion Nursing for Omnicare, a CVS Health company. “But we still service customers who have never accepted patients with infusion needs. They will need support to get a program up and running. Many customers have never admitted TPN patients. Education is going to be critical to their success.”

Although the number of patients needing infusion therapy isn’t expected to spike drastically, there will be fierce competition among skilled nursing providers to admit these patients. SNFs will soon be eligible for higher reimbursement when caring for such residents.

Under the Patient-Driven Payment Model, patients receiving TPN as their primary source of nutrition will receive seven points towards reimbursement in the Non-Therapy Ancillary (NTA) case mix group. TPN represents the second-highest point assignment in the non-therapy ancillary component.

Patients receiving other types of IV therapy will receive five points. There are only 15 conditions that are assigned a score of two or more. All other non-therapy conditions in the selected list of 50 conditions are assigned one point.

PREPARE TO GET PAID

Under PDPM, then, caring for patients with infusion needs is an

opportunity to provide specialty care and get paid well for it — but only if providers are prepared.

Omnicare is partnering with providers through its comprehensive Infusion Support Services program, which includes infusion program development, live and eLearning education offerings, competency validation tools and support, and a team of infusion nurses and pharmacists to provide ongoing guidance, monitoring and support.

It is important that providers start with the basics, including standard IV therapy education for the entire clinical staff. Omnicare offers Infusion education from basic to advanced, to support the management of clinically complex patients with infusion needs.

WALK BEFORE YOU RUN

IV therapy is complex. Start with simple hydrations and IV antibiotics. Once the staff is confident, move on to more complex therapies like TPN, Inotropes, and so forth.

Moving too aggressively could lead to costly hospital readmissions and poor patient outcomes.

Any effort to launch or upgrade an IV program should be set down in policies and procedures that allow facilities to standardize service practices. Omnicare provides all SNFs with a comprehensive Nurses' Infusion Therapy Manual that focuses on the provision of infusion therapies according to CMS guidelines and current standards of practice.

The company also offers competency assessment and educational support tools that build expertise and help staff perform new procedures with confidence.

“The nursing staff should be educated and competent before you begin accepting IV therapy patients,” Bishop said. “You need to learn to walk before you can run.”

DESIGNING FOR SUCCESS

As providers decide to expand the specialties that they can deliver, certain

consideration must be given to physical design and space.

Facilities must have an appropriately sized medication refrigerator to accommodate several bags at one time. Each TPN bag may be one to three liters in size. Storing multiple TPN bags will take up significant real estate in a small med room refrigerator.

Additionally, certain additives must be introduced to the parenteral nutrition bag by the nurse just prior to hanging due to instability. The process of introducing additives requires preparation in a clean med room that is free of dust and currents of air, and has running water for handwashing.

“NURSING STAFF SHOULD BE EDUCATED AND COMPETENT BEFORE YOU BEGIN ACCEPTING IV THERAPY PATIENTS.”

Gathering complete information from hospitals or other referring partners also will be critical to PDPM success. SNFs can earn NTA points, in some instances, up to a 60-day look back, so Bishop said it is essential that SNFs work closely with referring hospitals to improve the transfer of relevant medical records. Hospital transfer records also need to include specific information about the IV therapy and vascular access device.

Obtaining current orders, lab values and vascular access details will ensure your patient experiences a smooth transition of care from the hospital to your facility.

Omnicare provides infusion-specific pre-admission screening tools to guide you through obtaining clinical information that will promote positive outcomes.

MULTIPLE SPECIALTIES

Developing an inotrope clinical program to admit end stage heart failure referrals could be another subspecialty.

“These patients are typically very difficult to place because they are deconditioned and need ‘gentle’ rehab to prepare them for discharge to home on their inotrope,” Bishop said. “They typically cannot tolerate more than a few minutes of rehab at a time. Under RUG-IV, the limited rehab minutes did not make them particularly appealing admissions. Under PDPM, the NTA points will change that to a more favorable appeal.”

“The facilities that will win new patients under PDPM,” Bishop said, “will be those that can assure the hospitals they can manage them because they have the training and the tools they need.” ■



DIVING DEEP IMMEDIATELY

MEDICATION REGIMEN REVIEWS UPON ADMISSION REQUIRE PACE, EFFICIENCY

By Kimberly Marselas

Imagine a new patient arrives on a Friday afternoon, recovering from orthopedic surgery but also bringing with her prescriptions commonly associated with high blood pressure and diabetes. And then there's a third medication, with no readily-apparent matching diagnosis in the transfer paperwork.

In another time, staff might have waited until Monday to call the hospital and investigate the need for the mystery drug.

But in today's skilled nursing world — with its increased emphasis on value-based care and a new reimbursement model designed to embrace that philosophy — timing may be everything.

An efficient, near-immediate Admission Medication Regimen Review that focuses on resident characteristics and outcomes gives consultant pharmacists safe and secure access to patient records, even if the next scheduled site visit is several days out. Issues they unearth can feed a facility's game plan for information gathering, initial MDS completion and care planning.

Omnicare's software-based aMMR is meant to raise red flags about

duplicate medications, dosage errors or possible compliance issues. But at its core, it is designed to help facilities paint a more complete picture of a patient's needs.

"The clinical data exchange between the hospital and the skilled nursing facility often has been missing, incomplete or inaccurate," said Todd King, Pharm.D., CGP, Senior Director of Clinical Services for Omnicare, a CVS Health company. "The consultant pharmacist being close to that process can help SNFs with regulatory compliance by limiting duplicate therapy, unnecessary medications and inappropriate diagnoses."

UPON CLOSER INSPECTION

Omnicare's aMMR works for thousands of providers per year, helping them seize the opportunity to improve communication with others along the healthcare continuum. The review, triggered automatically by any new admission, covers hospital discharge documents and other forms accessible through almost any electronic health records system.

Potential problems are communicated immediately by the consultant pharmacist, by phone or secure email, as dictated by a standing relationship with each building served.

In addition to its focus on pharmaceutical therapies, a medication review done within 72 hours of admission informs a resident's case mix score under the Patient-Driven Payment Model. The review process also can help facilities fulfill their obligations under a new quality reporting measure and identify opportunities to improve the safety and quality of care — and potentially save money.

"It gives you opportunities to

evaluate diagnoses, look at therapies, look at treatments or high-dose medications and reassess,” King said. “On the flip side, it’s a great opportunity to identify potential cost savings, such as moving from a brand name to a generic, deprescribing or shifting away from additive therapies.”

The system also can produce reports on utilization of certain high-cost or avoidable medications, monthly drug use by category, residents taking a particular medicine, antibiotic use and other information that might support Quality Assurance and Performance Improvement (QAPI) goals.

Senior care consultant Patricia Boyer, MSM, RN, NHA, noted that medication review software that quickly connects physicians or other prescribers with detailed patient information enhances the timeliness of needed follow up care.

“When a pharmacist is involved in the electronic review of medications, it can greatly reduce the risk of adverse drug events,” she said. “It can also alert staff to potential regulatory issues with antipsychotic medications and antibiotics use that is not meeting requirements.”

MAKING RELATIONSHIPS COUNT

In addition to PDPM’s emphasis on antibiotic stewardship and its emphasis on reducing antipsychotic drug use, the Quality Reporting Program next year will cite facilities that don’t document and follow up on a medication regimen review. The measure seeks to ensure providers are looking for and responding to clinically significant medication issues during a stay, Boyer noted.

The initial MDS will ask whether a drug regimen review identified potential clinically significant medication issues and if the facility contacted a physician by midnight of the next day to complete recommended actions.

An automated process and a standing relationship with a consultant pharmacist equipped with software



An early medication review is a great opportunity to find potential cost savings, pharmacy experts maintain.

designed for SNFs can “drastically reduce” sentinel events, Boyer said.

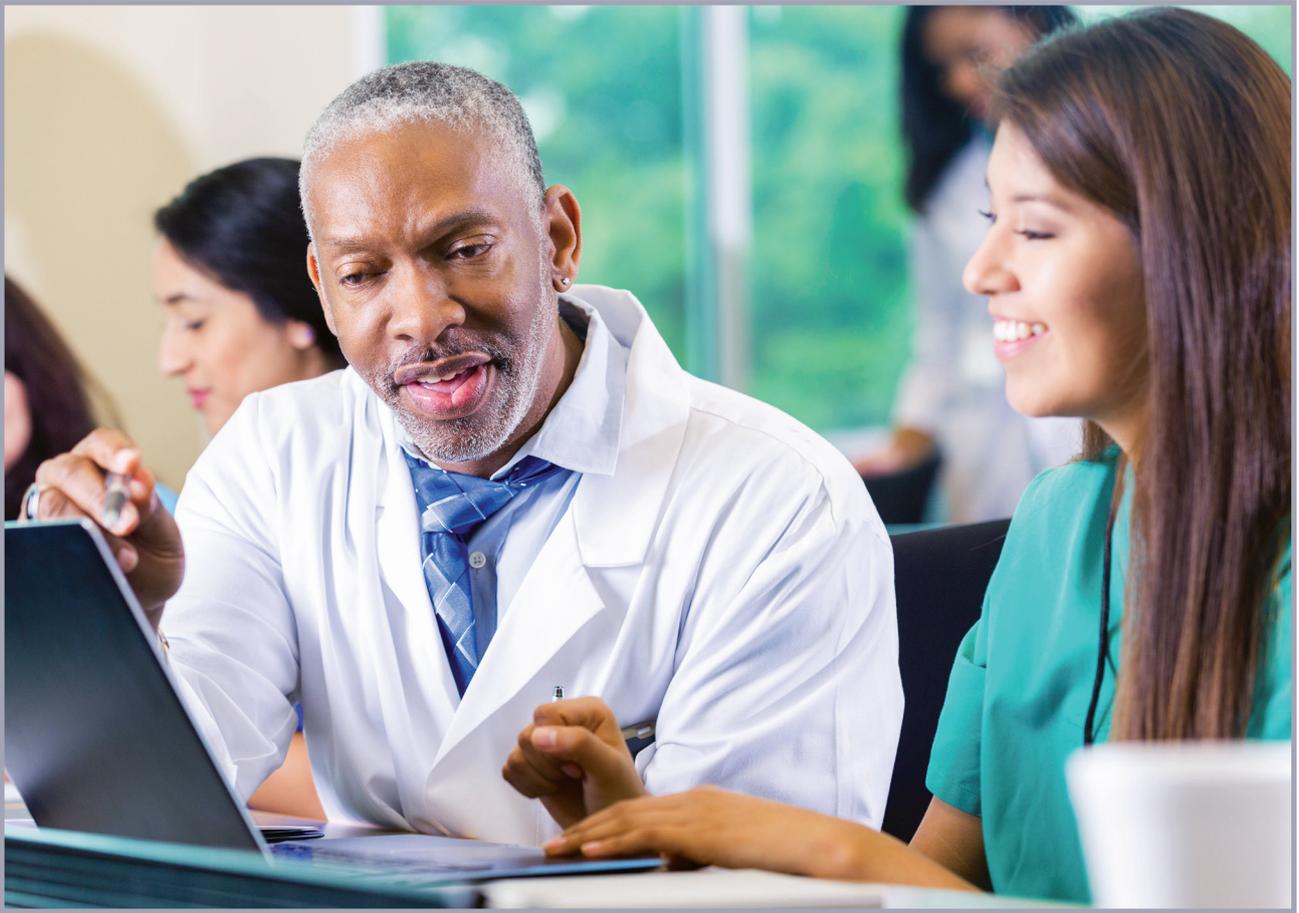
Shortened lengths of stay should push providers to act faster, rather than leaving problems for the patient or home health to handle after discharge. While some conditions get a payment boost during the first three days of treatment, providers will need to act with speed to ensure they figure out proper medications within that time frame.

For example, the pharmacist would alert the facility to an antipsychotic PRN for which a new order might soon be needed — or which the prescriber may want to consider

“WE REALLY NEED TO EXHAUST THE TECHNOLOGICAL MEANS THAT WE HAVE ... TO SEE AND ACT UPON PATTERNS.”

suspending in light of a patient’s condition and PDPM’s focus on use reduction. A pharmacist using aMMR also could spot potential cost savings, such as a patient who arrives on an IV drug but could be converted to a less expensive oral version if his condition improves by the three-day mark.

“We really need to push that medication review to the point of admission,” King said. “We really need to exhaust the technological means that we have to care for every patient and to make sure facilities are able to see and act upon patterns happening in their buildings.” ■



IT ALL COMES DOWN TO PROPER PREPARATION

STAFF EDUCATION WILL DRIVE WHETHER A FACILITY'S SYSTEM SUCCESSFULLY NAVIGATES PDPM AND ALL OF ITS PRIORITIES

By Kimberly Marselas

As the full shift to the Patient-Driven Payment Model progresses, skilled nursing operators are looking for opportunities to attract new partners and patients.

Vital to much of that positioning will be staff education that focuses on the kind of complex diagnoses rewarded with higher reimbursement rates under the new model — and on the diagnoses most prevalent in an industry routinely serving high-acuity patients.

PDPM was designed, in part, to help hospitals with a backlog of patients, many of whom no longer require acute care but previously might not have been able to find nursing home slots due to lack of reimbursement or lack of expertise on a particular condition. With better pay becoming available, the theory is that skilled nursing providers will clamor for that patient load.

“The nursing home that doesn’t have a plan — they’re still not going to be able to take these residents,” said Nancy Losben, R.Ph., CCP, FASCP, CG, Senior Director for Quality for Omnicare, a CVS Health company. “It’s not simply about education. It’s about the system you

will build so all of the equipment, the medication and the services complex patients need are there from day one.”

EXPERT ADVICE AVAILABLE

Consultant pharmacists stand ready to provide education and help providers build out new service lines, either onsite or through online education modules. Omnicare’s experts have already worked with hundreds of clients to develop better infection control programs (needed to accept vulnerable HIV patients), parenteral IV feeding programs (often associated with abdominal surgery, a colectomy or

malnutrition), dialysis and even organ transplant recovery.

Most nursing homes, Losben said, are very ready to handle chronic diseases but they need a refresher on certain modules, such as COPD management or diabetic foot ulcers. Both of those conditions, and 48 others, get additional reimbursement for extensive services under PDPM's non-therapy ancillary component.

A variety of related topics — including pain management, antimicrobial stewardship and specialty medication resources — are available through Omniview, which has been completely refreshed to include PDPM updates.

Omnicare also has worked with each of the facilities its serves to review formularies and ensure buildings are well-stocked for an influx of complex patients.

For instance, facilities that plan to accept patients with inflammatory bowel disease — 75% of whom are women, a mainstay in long-term care communities — will need to keep bladder and bowel appliances and ostomy bags at hand. For residents recovering from organ transplantation, preparation is even more critical. A single missed dose could lead to organ rejection.

“This is a very crisp service,” Losben said. “Upon admission, there is so much that must be planned for and expected.”

In the case of STAT supplies, Omnicare has worked with skilled care providers to revamp emergency kits. Any repeated STAT requests are now supplied as part of the back-up supply and those changes have been communicated to staff.

GETTING AHEAD OF THE GAME

Education efforts also must cover advanced planning and pre-admission readiness, Losben said. That will allow MDS coordinators or other liaisons to truly understand what patients need and to work with their pharmacists to make sure supplies are ordered to



Advance planning and pre-admission readiness are vital to make sure supplies are ordered to correspond with projected admission dates.

correspond with projected admission dates.

But providers shouldn't limit their PDPM preparation to pharmaceutical planning alone, Losben said. A multi-point effort that also involves therapy providers and medical staff, as well as electronic health records and analytics vendors, will create optimal solutions, she explained.

“THIS IS A VERY CRISP SERVICE. UPON ADMISSION, THERE IS SO MUCH THAT MUST BE PLANNED FOR AND EXPECTED.”

Thorough training also will enable skilled nursing operators to identify which conditions they can reasonably handle, and which they might want to avoid. Will adding a ventilator unit require too much of a staffing increase? Will accepting residents with multiple sclerosis who take high-dollar drugs actually bring in enough revenue? Does staff members' previous experience with burn patients mean a facility can solicit hospitals for related business?

“Nursing facilities that invest in education will be able to answer those questions and see what niche they fit into,” Losben said. “Only then can they market themselves to hospitals and network partners.” ■