

How Quality Will Pay for Hospitals Under New Reform Measures

Janice Simmons, for HealthLeaders Media , May 12, 2010

While most hospitals have focused on promoting quality care at their facilities to help decrease costs, quality care will take on a somewhat different meaning under the new healthcare reform law: Hospitals will feel the pressure to maintain continuous quality improvement or risk being penalized under reform incentives scheduled over the next several years, according to a PricewaterhouseCoopers' Health Research Institute report titled "Health Reform: Prospering in a Post-Reform World." (<http://www.pwc.com/us/en/health-industries/topics/health-reform.jhtml>)

According to the report, the new law can be expected to impact hospitals in three main areas:

- **Hospital readmissions.** Starting in October 2012, hospitals will be financially penalized by Medicare if they demonstrate "excess" readmissions within a 30-day period when compared to the "expected" risk-adjusted levels of readmissions. The readmissions are based on the measures for acute myocardial infarction, heart failure, and pneumonia.
- **Hospital payments based on value based purchasing (VBP).** Starting in 2013, hospitals will be paid according to a Medicare VBP program schedule, in which payments will be made based on hospitals' quality measure outcomes. VBP will measure hospital efficiency, patient satisfaction, and quality of care. These outcomes will be collected beginning October 2012.
- **Penalties for hospital acquired conditions (HACs).** Beginning in 2015, 1% of payments will be subtracted from hospitals with the highest rates of HACs—essentially those falling into the bottom quartile of hospitals when compared to the national average. This could result in a nationwide reduction of \$1.5 billion in payments over the next 10 years.

The message hospitals need to pay attention to is "don't get stuck in the bottom quartile, and work towards continuous quality improvement," according to the report. The bottom quartile will change from year to year as the quality performance of hospitals change. However, at least 1,000 hospitals will end up in the bottom quartile—regardless of the quality provided.

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Beginning in 2013, high scoring hospitals under VBP will receive a higher payment of 1%— which rises to 2% in 2017 and beyond. In addition to the direct financial impact, the reform law will require that an organization's quality metrics be publicly available and accessible.

In addition to the direct financial impact, hospitals also could feel the impact of consumerism. For years, healthcare has lagged behind in making information easily accessible to consumers, but this has been changing.

According to a 2009 PricewaterhouseCoopers consumer survey, individuals are using the Internet as a source for making decisions. Online content was found to edge out physicians as an information source: For instance, 48% of consumers said they use health websites to find information to make decisions about their healthcare.

Within this consumer realm, hospital quality information will move "beyond the organization and government websites" to health websites and consumer advocacy sites, the researchers note.

In addition, making more quality information available to consumers could impact a system's perception in the community and payers' contracting strategies with them. More informed decisions by patients could lead them away from organizations listed as "poor performers"—or those in the bottom quartile of hospitals.

For the typical hospital, being on the bottom quartile in terms of quality could mean millions of dollars lost annually. For instance, for a 300-bed community hospital with \$50 million in Medicare inpatient net revenue, failure to improve on hospital readmissions (a loss of about \$96,780), failure with VBP (a loss of \$750,000), and ending up in the lowest quartile for HAC (\$500,000), would create a drop of \$1.35 million in income.

In addition to Medicare, hospitals also will have to learn to live with cuts in Medicaid. Hospitals that care for high numbers of uninsured and Medicaid patients currently receive extra funding from Medicare and Medicaid under the disproportionate share program. But in 2014, Medicare DSH will be reduced 75%—the same year that the insurance exchanges and individual and employer mandates go into effect.

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TGH Pharmacy & Therapeutics (P & T) Committee UPDATE: September 2010



**Please visit Micromedex – FORMULARY ADVISOR for more details of the latest formulary decisions and access to the TGH Formulary. Micromedex – FORMULARY ADVISOR is available on any computer in the hospital with an internet browser!*

23.4% NaCl Final Plan

The P & T Committee discussed follow-up to the initial plan for use of 23.4% NaCl in refractory intracranial hypertension from the August meeting of the Critical Care Steering Committee. Dr. Agazzi (neurosurgery) and Dr. Decker (neurology) were in attendance.

The following recommendations were made by the Critical Care Steering Committee and approved by P & T Committee:

- Neurosurgery residents will have the ability to order 23.4% NaCl

- For any other service, orders for 23.4% NaCl must be written by either a fellow or attending level physician.

- MD must administer 23.4% NaCl (current practice)

- One vial of 23.4% NaCl will be stocked in approved critical care units' AcuDose cabinets and will not be available for nursing override. A pharmacist will review and profile the order.

- Revised order sets will be made available and the vials stored in lock-lidded containers in the approved unit AcuDose cabinets.

Sevelamer carbonate (Renvela)

Sevelamer carbonate (Renvela) is indicated for the control of serum phosphorus in patients with chronic kidney disease who are on dialysis. The current formulary alternative is sevelamer hydrochloride (Renagel). Available data suggest no differences in efficacy or safety between the two products in patients requiring phosphate binding therapy. The availability of the powder formulation of Renvela allows for administration of this phosphate binder via feeding tubes in patients who are unable to swallow whole tablets.

The P & T Committee approved the addition of Renevela tablets and powder packets, and the removal of Renagel 800mg tabs from the TGH formulary. A therapeutic interchange with equivalent dose and frequency was approved for 800 mg doses or higher. The exception to this interchange is Renagel 400mg capsules, which will remain on formulary, as patients are occasionally admitted on this low dose and there is no Renvela preparation equivalent to 400mg dose.



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Intravenous Immune Globulin Utilization (Attachment V)

The P & T Committee reviewed current utilization of IVIG as a follow-up to considerable increase in use compared to last year (approximately \$500,000 increase over FY09). A snapshot of IVIG use was created based on diagnosis, procedures and location of use. The most significant increase in use has been noted in the transplant population. Increased use in transplant patients can be attributed to improved technology for detecting antibodies in this patient population and the use of IVIG is becoming the standard of care. Current guidelines for IVIG use (2008) at TGH were reviewed and are currently being revised. The revised guidelines will be presented to the Committee for approval in the near future.



Pharmaceutical Shortage Update

A policy for the management of drug product shortages and a shortage communication plan was reviewed by the P & T Committee. The process for communication of shortage information to affected providers was outlined in the policy. The following strategies to optimize physician notification of critical product shortages were discussed:

- Use the Precise alert, similar to the ER information alert that comes up when providers log onto Precise. This methodology would work best for critical shortages that need to be communicated quickly.

- Discuss product shortage management at the Annual Medical Staff meeting.

- Add a methodology for emergent P&T approval if action needs to be taken prior to the next scheduled meeting.

- Prioritize shortages on update list based on criticality and impact.

Currently, options in Precise for notification are being investigated and slides are being prepared for presentation at annual Medical Staff meeting. A statement was added to the policy that chairperson can make temporary formulary changes until the next time the full Committee meets with input on the shortage management plan from prescribers and medical section chiefs affected by the shortage. The policy was approved with recommended changes and additions.



Please visit [Micromedex – FORMULARY ADVISOR](#) for a complete and current list of pharmaceutical shortages



WE'RE ON THE WEB
WWW.TGH.ORG

TGH Welcomes our new Physicians



The physicians below were added to TGH staff: 10/31/2010

Joseph M. Barron, PSY	Psychology
Fernando Diaz-Mori, MD	Family Practice
Jason A. Edwards, DMD	Dentistry
Miguel A. Espinal-Santos, MD	Hospital Medicine
Paul M. Heimbecker, MD	Gynecology
Laxmi D. Koya, MD	Gastroenterology
Shana M. Laflin, MD	Hospital Medicine
Thieu P. Nguyen, MD	Pediatrics
Edwin Ramos, MD	Neurological Surgery
Andrea N. Singh, DPM	Podiatry
Tuan H. Vu, MD	Neurology

KUDOS TO OUR PHYSICIANS!

Congratulations to the following physicians who were recognized by their patients in the form of personal letters to TGH leadership.

Dr. Jeetpaul Saran, Dr. Michael Berlowitz & Dr. Alexander Rosemurgy



This newsletter is produced by Tampa General Hospital's Quality Improvement Department.

All comments, responses or suggestions are welcome and should be directed to:

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