



## Value Based Purchasing....Coming Soon From:



Chuck Bombard, Director, Quality Improvement

Value-Based Purchasing, the government's budget-neutral way to get hospitals to achieve high quality care as evidenced by attaining high scores on clinical process measures (Acute Myocardial Infarction (AMI), Congestive Heart Failure (HF), Pneumonia (PN), Surgical Care Improvement Project (SCIP)) and experience of care measures (patient satisfaction surveys) or else lose money, is about to make its presence felt. While not a law just yet, the proposed regulation's comment period ended March 8<sup>th</sup> and the anticipated final rule is expected soon.

The program, mandated as part of the Affordable Care Act, will require hospitals to pony-up 1% of their Medicare payments in FY 2013 (October 1, 2012), increasing each year thereafter by 0.25% to 2% in FY 2017 and beyond. The "pot" of available dollars will then be distributed back to hospitals based upon how well they comply with the core measure indicators and score on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey. The core measures are more heavily weighted at 70% compared to the HCAHPS survey, weighted at 30%. Depending on results, some hospitals may make more than they contribute, others will break even, and some will lose money.

### The 17 clinical process measures that will be part of the 2013 Value-Based Purchasing initiative include the following:

- AMI – Aspirin prescribed at discharge
- AMI – Fibrinolytic therapy received within 30 minutes of hospital arrival
- AMI – Primary PCI received within 90 minutes of hospital arrival
- HF – Discharge instructions
- HF – Evaluation of Left Ventricular Systolic Function
- HF – ACE inhibitor or ARB for LVS dysfunction
- PN – Pneumococcal vaccination
- PN – Blood cultures performed in ER prior to initial antibiotic received in hospital
- PN – Initiation of appropriate antibiotics for CAP in immunocompetent patients
- PN – Influenza vaccine

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SCIP – Surgery patients on a beta blocker prior to arrival that received beta blocker during the perioperative period

SCIP – Surgery patients with recommended venous thromboembolism prophylaxis ordered

SCIP – Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery.

SCIP – Prophylactic antibiotic received within one hour prior to surgical incision

SCIP – Appropriate prophylactic antibiotic selection for surgical patients

SCIP – Prophylactic antibiotics discontinued within 24 hours after surgery end time

SCIP – Cardiac surgery patients with controlled 6 AM postoperative serum glucose

The rules for data abstraction related to the above measures are very strict and abstractors are bound to follow the letter of the law as written by CMS. If the provider feels that there is a legitimate reason not to follow the recommended treatment, they need to document their rationale in the medical record so we can possibly avoid the deviation being held against us.



The HCAHPS survey that discharged patients will receive covers the subjects of communication with nurses and doctors, responsiveness of the hospital staff, pain management, communication about medicines, cleanliness and quietness of the hospital environment, discharge information and overall rating of the hospital.



Scoring for the process and patient experience measures is rather convoluted and involves two scores, an achievement score and an improvement score. Hospitals would receive the higher of their achievement or improvement score for each measure. Hospitals that score at least at the minimum achievement threshold (national median score (50<sup>th</sup> percentile) for all hospitals in the baseline period 7/1/09 – 3/31/10) would receive at least some points for achievement. Hospitals' improvement scores will be assigned by awarding points based on how much the hospital has improved (current performance compared to its own performance during the baseline period). Simply put,

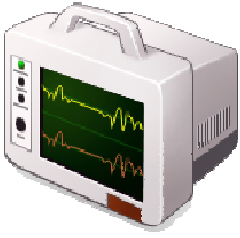
achievement score comparison is made against all hospitals and improvement score comparison is made against your own hospital. Scores for the HCAHPS measures would be calculated in a similar fashion and would also include a component for assessing consistency among the hospital's HCAHPS scores.

CMS' rationale for the move to Value-Based Purchasing lies in the current payment system rewarding quantity, rather than quality of care, and providing neither incentive nor support to improve quality of care. Value-Based Purchasing, which links payment more directly to the quality of care provided, is seen as the solution to that dilemma. Value-Based Purchasing is about to become part of every hospital's clinical and administrative life for the foreseeable future, with plans for considerable expansion as early as 2014. Tampa General will need all of our physicians' support to compete on the Value-Based Purchasing playing field, and we appreciatively solicit that support.



## Defining Telemetry

Janet Denmark, RN, MSN, CNS, ACNS-BC  
Clinical Nurse Specialist, Cardiovascular Services



**Tampa General has recently clarified the differences between, medical and cardiac telemetry units. In addition, the Adult Stepdown Unit has developed some criteria to help define their practice.**

**Medical telemetry**, formerly known as remote telemetry, is defined as providing continuous cardiac monitoring at a central or remote station. Admissions may be limited by diagnosis, results of cardiac markers, rhythm, and symptoms. In this setting, RN's are unable to administer vasoactive medications or continuous infusions (except Diltiazem). However, they may administer select intravenous push medications. If multiple doses or incremental adjustments of these approved medical telemetry IV medications are required for patient stability, a change in medication or level of care is indicated.

Medical telemetry is appropriate for patients with:

1. Stable rhythms.
2. Chronic atrial fibrillation/flutter with ventricular response greater than 50 and less than 110 beats per minute
3. Completed first set of cardiac enzymes within normal values and a non cardiac diagnosis.
4. Systolic blood pressure greater than 80mm Hg

Medical Telemetry is not appropriate for patients with

1. Symptomatic Bradycardia / Tachycardia or HR less than 50 or greater than 120
2. New onset Afib/flutter
3. Second or third degree heart block
4. Sustained VT
5. Rule out MI
6. Suspected cardiac related Chest Pain
7. Any positive cardiac enzyme (Troponin greater than 0.2 µg/L)
8. Patients with prolonged QT intervals
9. Hemodynamic instability - signs or symptoms of decompensation
10. Patients requiring continuous IV cardiac drug administration other than Diltiazem for rate control

**Cardiac Telemetry** is defined as providing continuous cardiac monitoring at a central station. The RN is able to administer selected medications, including vasoactive medications and continuous infusions.

Cardiac Telemetry is appropriate for patients with:

1. Atrial fibrillation/flutter
2. Non-Sustained ventricular tachycardia
3. First or Second degree heart block
4. Symptomatic bradycardia with a ventricular rate greater than 40
5. Patients requiring continuous IV cardiac drug administration per hospital policy TX-58
6. Rule out MI / Acute Coronary Syndrome
7. Chest pain
8. Incomplete and/or elevated troponins and/or other cardiac enzyme levels

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9. Acute EKG changes
10. Able to maintain a systolic BP greater than 90

The Adult Stepdown Unit, ASDU, (4F) is a transitional unit for patients that require intense respiratory support and continuous cardiac monitoring. Care is provided for patients of varying acuities with a significant potential for life-threatening changes that require more frequent nursing assessment.

Patients appropriate for the ASDU include:

1. Respiratory conditions requiring a ventilator via tracheostomy.
2. CPAP/BIPAP patients with a tracheostomy
3. Stroke
4. Epilepsy
5. Neurosurgery
6. New onset of seizures
7. Roto Rest Beds
8. Traumatic Brain Injuries
9. Spinal cord injuries
10. Patients with peritoneal dialysis
11. Trauma
12. Major abdominal surgery
13. Urology
14. Cardiology patients: CMO, CHF



The ASDU is *not* appropriate for patients with:

1. Complicated acute myocardial infarction with temporary pacemaker, angina, hemodynamic instability, significant pulmonary edema or significant ventricular dysrhythmias.
2. Patients with acute respiratory failure who are recently intubated or are at imminent risk of requiring intubation.
3. Patients requiring invasive hemodynamic monitoring with a pulmonary artery or left arterial catheter, or an intracranial pressure monitor.
4. Patients in status epilepticus.
5. Patients with catastrophic brain illness or injury who are not to be resuscitated and are not candidates for organ donation.
6. Patients from whom aggressive modalities of care are being withheld or have been withdrawn, such as comfort measures only.

**To help assure availability of beds in the ASDU, patients may be triaged to another appropriate level of care. When a patient's physiologic status has stabilized and the patient meets criteria for acute care floor placement, charge persons will be responsible to triage patients with the help of the physician, the nurse manager, clinicians and nursing supervisors.**

# KUDOS!

The letters on this page represent appreciation expressed by patients who were extremely happy with the care they received from their physician. We congratulate Drs. Susan Smith, Dawn Palaszewski, and Kiran Rao on their recognition for outstanding service.

April 8, 2011

Dear Mr. Ron Hytoff,

On March 22, 2011 I had the pleasure of delivering my third child at TGH. I received all my prenatal care with the USF Physicians group. I am writing to inform you of the amazing care I received from both Dr. Dawn Palaszewski and Dr. Kiran Rao with USF OB.

The majority of my prenatal care for this pregnancy was with Dr. Palaszewski. From the first day we met I was impressed. She has a very upbeat, pleasant, calming demeanor. She always took the time to listen, review my plans of pregnancy and delivery, and most importantly let me make the decisions regarding my care.

My first encounter with Dr. Rao was towards the end of my second pregnancy. He too impressed me right away with his calm, pleasant, very respectful demeanor. Dr. Rao was also very knowledgeable, patient, and took time to explain all possibilities with my second delivery as my first was a c-section. After trying to labor for many hours with my second child, I ended up with a c-section performed by Dr. Rao, which I was very pleased with.

During one of my early prenatal visits with this recent third pregnancy I ran into Dr. Rao in the office. Since he is currently doing a fellowship, he was not able to see me for my prenatal care. However, when I told him I was expecting he immediately offered to perform my repeat c-section if that was the route I was to choose. I was so impressed with his offer as well as relieved to know that I would be able to receive great care again. He provided me with his email address to organize a delivery date when time got closer. Several months before my due date he already committed to a date and we scheduled the c-section. Not only was he going to be there, he also organized with Dr. Palaszewski that she would be there too as she was providing the prenatal care. Talk about continuity of care, wow!

On March 22 I showed up for my scheduled c-section and was immediately welcomed by the great nursing staff and Dr. Rao. We started the prep procedures and discussed the plan. I was a bit nervous, but easily calmed and reassured by my doctors. Everything was settled and we were just waiting

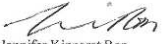
on anesthesia so with time to kill Dr. Rao took my husband to get something to eat to assure he wouldn't hit the floor in the OR. Once again, he went above and beyond what I could expect from any doctor.

It was almost time for surgery and I received some unexpected news from anesthesia, I was going to require general anesthesia. This was a big surprise and upset for me as it meant my husband was not going to be with me during the delivery, I would be unaware of the birth of my child, and miss her first breath and cry. I was quite upset and nervous for my baby, but I knew that I had the two best doctors possible to assure a quick and safe delivery. When I entered the OR I saw my doctors who provided comfort and reassurance. As I looked around the OR at all the staff, who were basically strangers to me, I was so grateful for Dr. Rao and Dr. Palaszewski's presence which helped me feel a little less alone. I just kept thinking, thank goodness we scheduled this c-section ahead of time and I have these two doctors here.

My amazing care continued after surgery as well. My doctors assured my pain was well controlled and I had anything I could possibly need. Dr. Rao himself followed up with me everyday even though he was not on call. He assured my continuity of care throughout my hospital stay. My discharge was prepared by him first thing in the morning to prevent any delays as I felt I was ready to get home. I could not have asked for nor needed anything more.

Dr. Rao and Dr. Palaszewski certainly deserve recognition for the amazing care they provided to me throughout my pregnancy and delivery. They consistently demonstrate great skill, talent, bedside manner, and care. They are definitely "very TGH".

Sincerely,



Jennifer Kinneret Ron

Jonathan and Gianine Peterson  
729 Straw Lake Dr.  
Brandon, FL 33510

April 3, 2011

Mr. Ron Hytoff  
President and CEO  
Tampa General Hospital  
2 Tampa General Circle, 6<sup>th</sup> Floor  
Tampa, FL 33606

Dear Mr. Ron Hytoff:

This letter is in reference to Dr. Susan Smith, who recently delivered our baby boy Giordan on January 30, 2011. Previously, Dr. Smith had delivered our other child Giulian.

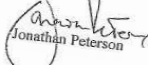

Rarely have we written a letter of commendation for a job well done or for service that greatly exceeded our expectations. The excellent care we received from Dr. Susan Smith for the birth of our child Giordan compels us to write such a letter.

From the monthly checks ups to see that baby was developing to the very moment Giordan went home, Dr. Smith was competent, kind and attentive. What impressed us amongst many things was Doctor Smith's genuine care and attention. An example of this was when Dr. Smith visited Giordan's mother Gianine while she was recovering from the surgery. Dr. Smith also visited baby Giordan in the NICU on several occasions. Additionally, on the day Giordan went home Dr. Smith came to see mother and baby and wish them well as they left the hospital!

Imagine! The delivering Doctor makes a courtesy call on the recovering mother after the birth and even bids baby farewell as he leaves the hospital! Where is this caring spirit of the physician found in today's hectic profit-driven environment? It is found alive and well at Tampa General Hospital, because of Dr. Smith!

Lastly, we would like to compliment the management staff of Tampa General Hospital for employing such qualified and caring physicians as Dr. Smith! Tampa General is well suited to meet the needs - and exceed the expectations - of the community with doctors as Dr. Smith on its staff.

Best Regards,

Jonathan Peterson      Gianine Peterson

Cc: Dr. Jerry Yankowitz,  
Dr. Cathy Lynch -  
Mr. Cedell McKeever  
Ms. Veronica Martin  
Dr. Susan M. Smith

## This month's KUDOS go to:

- Dr. Debbie Rinde-Hoffman, Dr. Cedric Sheffield,  
Dr. Siva Kumar, Dr. Melida Hayes,  
Dr. Fadi Matar, Dr. Steven Goldin,  
Dr. Cuc Mai, Dr. Keith Chandler,  
Dr. Sowsan Rasheid, Dr. David Wein,  
Dr. Kaivon Madani, Dr. Kenneth Gustke,  
Dr. Hailang Yang, Dr. Daniel Riggs,  
Dr. Richard Weibley, Dr. David Pettigrew,  
Dr. Rene Chapados, Dr. Preceousa Serna,  
Dr. Susan Smith, Dr. Kiran Rao  
& Dr. Dawn Palaszewski*

## TGH Pharmacy & Therapeutics (P & T) Committee UPDATE: February 2011

*[\\*Please visit "tgh pharmacy" link for more details of the latest formulary decisions and access to the TGH Formulary.](#)*

*["tgh pharmacy" link gives you access to Micromedex and FORMULARY ADVISOR - available on the desktop of any computer in the hospital with an internet browser!](#)*



### • Denosumab (Prolia)

- Denosumab (Prolia) was added to the TGH ambulatory clinic formularies at Kennedy and Health Park Clinics. The agent is restricted to use in post-menopausal women at high risk for fracture. Denosumab (Prolia) is indicated for the treatment of postmenopausal osteoporosis in women who are at high risk for fracture defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant of other available osteoporosis treatment therapies. Our current formulary agent is zoledronic acid (Reclast). Denosumab is a monoclonal antibody that prevents the activation of osteoclasts leading to decreases in bone resorption, increases in bone mass and bone density. The injection is administered every six months and must be administered in a health care setting. It is contraindicated in patients with hypocalcemia and will require a BMP or CMP prior to each administration and a correction of calcium levels if needed.
- It is important to note that denosumab is also marketed as (Xgeva) in a different dosage for for the prevention of skeletal-related events in patients with bone metastases from solid tumors.
- Additionally, patients will receive medication counseling prior to administration and receive a Medication Guide for Prolia per FDA Risk Evaluation Mitigation Strategy (REMS) requirement.

### • Everolimus (Zortess)

- Everolimus (Zortess) is a new immunosuppressive agent that is FDA approved for prophylaxis of organ rejection in adult patients at low-moderate immunologic risk in kidney transplant recipients. The agent can also be used in combination with basiliximab and concurrently with reduced doses of cyclosporine and corticosteroids. Additionally, the agent has been studied in heart, liver and lung transplant patients.
- FDA approval was granted subsequent to two clinical trials that were performed in kidney transplant recipients. Both studies showed equivalent efficacy between everolimus and mycophenolate in preventing renal transplant rejection. It is important to note that close monitoring of everolimus levels is required and currently this is a send-out lab with 24 hour turn around time.
- It is also important to note that use in patients at high immunologic risk and safety/efficacy in pediatric patients (<18 years old) has not been established.
- Additionally, everolimus is the active compound in another FDA approved product under the trade name Afinitor<sup>®</sup>. Afinitor contains higher doses of everolimus for the indication of renal cell carcinoma.
- Zortess was added to the TGH formulary and restricted to ordering by the transplant services. The role of the agent will be to serve as an alternative immunosuppressant choice for prevention of transplant rejection. The Committee supported the recommendation to set up on-site everolimus serum level monitoring through laboratory services.

### • IV to PO conversion protocol expansion

- The P & T Committee approved an expansion of IV to oral conversion protocol to include additional antimicrobial agents: metronidazole, clindamycin, rifampin, voriconazole, sulfamethoxazole/trimethoprim, and minocycline.

*(Continued on page 7)*

(Continued from page 6)

- Changes to protocol have been discussed and approved by USF ID and ID Associates of Tampa Bay as well as the TGH Antibiotic Stewardship Program. The protocol has been further revised with more exclusion criteria in order to focus the conversion to only the most appropriate patients.
- The revised protocol is set for Medical Executive Committee review for final approval.

• **Medication safety plan annual review**

- Sarah Hein, Pharm.D. presented the annual review of the medication safety plan, focusing on areas where significant progress was made: selection of Epic as our EMR vendor, standardization of CRRT process, Antimicrobial Stewardship Program, heparin changes in ED, smaller insulin vials, and insulin u-500 guidelines. Risk assessment is mostly tied to usage of paper (e.g., orders, charts, MARs, etc), and manual system for documentation. The majority of our risks will be addressed when we convert to EMR in October 2011.
- Assessment of epidural pumps is currently in progress.
- The Committee accepted the recommendation for further review of new risks that will arise with the EMR and bar coding of medications.



• **Lithium monitoring protocol**

- A Lithium monitoring program has been developed through collaboration of USF Psychiatry and the TGH Psych Clinical Practice Improvement Team. This program assures lithium levels have been ordered when patients are started on lithium, admitted on lithium therapy or have dose adjustments during chronic lithium therapy.
- The P & T Committee approved the program, and it is set for Medical Executive Committee for review and approval.

• **Pharmaceutical Shortage Update**

- As a reminder, you can access the latest information on drug shortages by clicking on the “tgh pharmacy” icon located on any TGH computer in patient care areas. This link takes you directly to this pertinent information. This bypasses the need to go through the Micromedex homepage and navigate to formulary advisor to see TGH specific information.
- **Azithromycin therapeutic interchange for IV erythromycin.** The intravenous form of Erythromycin has historically experienced cycles of product shortage. The below interchange will be implemented automatically during IV erythromycin shortages. The erythromycin IV shortage interchange has been approved by the P & T Committee, L&D physician group, and the TGH Antibiotic Stewardship Program. The interchange is as follows:

	Current Management	Shortage Plan Interchange
Preterm Premature Rupture of Membranes Management (PPROM.)	Erythromycin 250 mg IV q6hr x 48 hrs, then Erythromycin 333 mg PO q8hrs x 5 days.	<i>Azithromycin 500mg IV daily x 48 hrs, then Erythromycin 333 mg PO q 8hrs x 5 days.</i>

**Please visit “tgh pharmacy” link on any patient care computer or Micromedex – FORMULARY ADVISOR for a complete and current list of pharmaceutical shortages.**



WE'RE ON THE WEB  
[WWW.TGH.ORG](http://WWW.TGH.ORG)

# TGH Welcomes our new Physicians

The physicians below were added to TGH staff: 2/28/2011



- |                            |                    |
|----------------------------|--------------------|
| Suzanne N. Benjamin, MD    | Emergency Medicine |
| Ronald F. Delgado, MD      | General Surgery    |
| James M. Hurst, MD         | Surgery            |
| Johnny Kao, MD             | Radiation Oncology |
| Mary Koshy, MD             | Radiation Oncology |
| Arthur J. Labovitz, MD     | Cardiology         |
| Hardeo K. Panchoosingh, MD | Pediatrics         |
| Janella L. Park, MD        | Radiation Oncology |
| Henry Rodriguez, MD        | Pediatrics         |
| Dima Sawalha Turpin, MD    | Pediatrics         |
| Lana L. Soyla, MD          | Pediatrics         |

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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