Hospitals in a Changing Healthcare Environment

Business, Professionalism and Justice

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Changing culture…

- Health Care Reform puts major culture change into play in hospitals.
- It puts quality improvement and patient safety & satisfaction at the real top of the list.
- It changes the relationship between physicians and hospitals.
- It brings ACCOUNTABILITY.
## Timeline of Reforms

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>30% indoor smoking ban</td>
</tr>
<tr>
<td>2012</td>
<td>$20,000 in Medicaid payment to manufacturers for drugs</td>
</tr>
<tr>
<td>2013</td>
<td>$3,700 million in Medicare payments to hospitals for quality care</td>
</tr>
<tr>
<td>2014</td>
<td>Expansion of Medicaid to 133% poverty level</td>
</tr>
<tr>
<td>2015</td>
<td>Expansion of Medicaid to 180% poverty level</td>
</tr>
<tr>
<td>2016</td>
<td>60% increase in “Cadillac” plan</td>
</tr>
</tbody>
</table>

## Impact of the CURES Act

### 2010 – 2013

1. Reimbursement impact: 1.55% = $13 million GME = $5.7 million *AHR = $10 million
2. Employee benefits cost could increase slightly

### 2014 – 2016

1. Reimbursement impact: LTPPP = $69 million GME = $13.3 million *AHR = $5 million
2. Impact of more publicly insured patients

## Growth Rate of Treatment Between 2010 – 2016

### Cost drivers

1. Advanced Imaging = 14%
2. Cardiovascular surgery = 16%
3. Vascular surgery = 13%

### Enrollees

1. 55 – 65 = 30 million
2. 55 – 60 = 10 million
3. 60+ = 7 million

## Other Initiatives

1. Reduce care around Medicaid target
2. Shift services from hospital to sub-acute
3. Breakdown costs in the
4. Use of non-FTD professionals
5. Opt out of employee benefits
6. Shift to episodic in all categories from cancer, spine, etc. and even nursing homes

### Market Expansion

- Significant expansion of opportunities and coverage
- Significant increase in potential revenue

### Regulation and Restructuring

- Cost drivers and savings opportunities
- Impact on patient outcomes and quality
• Value Based Purchasing will penalize hospitals for avoidable or preventable conditions that are:
  – High volume; high cost
  – Greatest morbidity and mortality
  – Wide reported variations in care despite published evidence and guidelines
Are we really all that good?

- Hospitals all claim high quality. “Top in Chicago, Top in Chicago’s western suburbs, Top per our patient survey…”

- Objective data might tell us otherwise. Look at Medicare.gov for comparison information.

- Chicago Tribune March 31, 2011: How Safe is Your Hospital?
1st challenge - public reporting

• Now our outcomes data is available
• We initially/continually challenge the methodology
• But, inside our hospitals we learned what we are and are not good at.
• We have worked at it for several years, but 10 years after IOM report, little progress. Now our livelihoods depend on it.
Medicare tells all on the web

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>LOYOLA UNIVERSITY MEDICAL CENTER</th>
<th>ELMHURST MEMORIAL HOSPITAL</th>
<th>LOYOLA GOTTLIEB MEMORIAL HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who reported that their nurses &quot;Always&quot; communicated well.</td>
<td>73%</td>
<td>74%</td>
<td>72%</td>
</tr>
<tr>
<td>Patients who reported that their doctors &quot;Always&quot; communicated well.</td>
<td>77%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Patients who reported that they &quot;Always&quot; received help as soon as they wanted.</td>
<td>53%</td>
<td>56%</td>
<td>56%</td>
</tr>
<tr>
<td>Patients who reported that their pain was &quot;Always&quot; well controlled.</td>
<td>67%</td>
<td>67%</td>
<td>66%</td>
</tr>
<tr>
<td>Patients who reported that staff &quot;Always&quot; explained about medicines before giving it to them.</td>
<td>59%</td>
<td>59%</td>
<td>55%</td>
</tr>
<tr>
<td>Patients who reported that their room and bathroom were &quot;Always&quot; clean.</td>
<td>64%</td>
<td>62%</td>
<td>67%</td>
</tr>
<tr>
<td>Patients who reported that the area around their room was &quot;Always&quot; quiet at night.</td>
<td>53%</td>
<td>49%</td>
<td>49%</td>
</tr>
<tr>
<td>Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.</td>
<td>82%</td>
<td>82%</td>
<td>75%</td>
</tr>
<tr>
<td>Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).</td>
<td>66%</td>
<td>62%</td>
<td>54%</td>
</tr>
<tr>
<td>Patients who reported YES, they would definitely recommend the hospital.</td>
<td>73%</td>
<td>68%</td>
<td>58%</td>
</tr>
</tbody>
</table>
Starting in July 2011 - the squeeze is on

- Payment penalties for readmissions within 30 days

- Measurement period underway for patient satisfaction penalties-CMS says incentive, but the incentive is funded by reducing payments, 1% initially, and up to 2% in 2017.

- And, in other arenas RAC audits are adding scrutiny to hospital admissions vs. observation stays.
Physicians and Hospitals must change their relationship

- Tensions between hospitals and doctors mount as hospitals feel accountable for doctor performance
- Doctors are overwhelmed with regulations/rules: Joint Commission, CMS, and internal hospital policies.
Partnerships begin to look optimal

- Hospitals seek ways to inform physician practice
  - Right admission (inpt vs. obs)
  - Managed LOS
  - Follow-up protocol to avoid 30 day readmission
  - Physician’s feel a threat to their income
  - Hospital feels like the CMS police.
How do we get to the finish line?

- Hospitals must become accountable NOW. Not necessary to implement an ACO structure, but doing all the right things is critical.
- Physician partnership will continue to be essential
- Fiscal controls will become more important than ever
- Understanding the drivers of quality and safety will be foremost effort.