COUNCIL ON CLINICAL & QUALITY ISSUES

Maryland
Hospital Association

October 15, 2024

MHA Offices
6820 Deerpath Road
Elkridge, MD 21075

Maryland
Hospital Association

COUNCIL ON CLINICAL & QUALITY ISSUES

Tuesday, Oct. 15, 2024, 9:30-11:30 a.m.

AGENDA

Time	Item	Presenter
9:30 a.m.	**Welcome and Consideration of July 24, 2024 Meeting Minutes**	David Maine, M.D., Chair
9:33	**Meeting Objectives**	Tequila Terry, Senior Vice President, Care Transformation & Finance
9:35	**HCAHPS Collaborative** **Objective:** HSCRC staff will describe the goal of the collaborative with MHA, the timeline, and next steps	Jonathan Sachs, Consultant, HSCRC
10:05	**MHA Board of Trustees Priorities – Quality Implications** **Objective:** MHA's Board of Trustees approved three priorities for MHA to pursue on behalf of the field to be successful in the current legislative and regulatory environment. The group will review these priorities and the potential quality-related opportunities that align with the BOT priorities. **Discussion Questions:** 1. Which of HSCRC's PMWG objectives most closely align with each of the BOT priorities? 2. Are there quality or population health issues that should be prioritized that don't quite relate to the BOT priorities?	Brian Sims, Vice President, Quality & Equity
10:35	**Adverse Event Report Action Plan** **Objective:** To provide an overview of MHA's action plan aimed at proactively addressing the anticipated findings to be released in OHCQ's annual Hospital Safety Report. Expecting an increase in adverse events, the goal is to ensure the reported data is	Tequila Terry

properly contextualized and that future data collection and reporting efforts prioritize quality improvement.

Questions:

1. What strategies has your hospital implemented to improve safety and mitigate adverse events?
2. What support do you need from OHCQ to facilitate improvement efforts?

10:50 **Emergency Department and Hospital Throughput Policy Update** — Brian Sims

Objective: To brief council members on the latest developments related to the ED LOS policy and the ED Best Practices Incentive policy.

Discussion Question:

1. What guiding principles should steer our advocacy on the Best Practices Incentive policy?

11:20 **2025 Topic Planning: Civica Rx Drug Supply** — Tequila Terry

Objective: To introduce Civica Rx information in preparation for the next CCQI meeting.

11:25 **Recap Action Items & Next Steps** — Tequila Terry

11:30 **Adjourn** — David Maine, M.D.

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COUNCIL ON CLINICAL & QUALITY ISSUES

Membership Roster
Fiscal Year 2025

David Maine, M.D., Chair
President & Chief Executive Officer
Mercy Health Services
Baltimore

Michele Martz, Vice Chair
President
UPMC Western Maryland
Cumberland

Mohammed Shafeeq Ahmed, M.D.
President
Johns Hopkins Howard County Medical Center
Columbia

Laural Brinkley*
Chief Nursing Officer
Calvert Health Medical Center
Prince Frederick

John Chessare, M.D.
President & Chief Executive Officer
Greater Baltimore Medical Center
Baltimore

Griffin Davis, M.D.
Chief Clinical Officer
Holy Cross Health
Silver Spring

Angela Green
Vice President, Safety and Quality
Johns Hopkins Health System
Baltimore

Kathryn Fiddler, DNP
Vice President, Population Health
TidalHealth
Salisbury

Heather Kirby
Vice President, Integrated Care Delivery, and Chief Population Health Officer
Frederick Health
Frederick

David Lang, M.D.
Chief, Office of Patient Safety & Clinical Quality
NIH Clinical Center
Bethesda

Ralph Lebron, M.D.*
Medical Director, Quality & Patient Safety
Mercy Medical Center
Baltimore

Stuart Levine, M.D.
President, MedStar Franklin Square Medical Center, and Senior Vice President, MedStar Health
Baltimore

Stephen Michaels, M.D.
President, MedStar Southern Maryland Hospital Center, and Senior Vice President, MedStar Health
Clinton

Jonathan Patrick, M.D.
Senior Director, Hospital Quality Performance Co-Chair
MedStar Health
Baltimore

Matthew Poffenroth, M.D.
Senior Vice President & Chief Physician Executive
LifeBridge Health
Baltimore

Michael Anne Preas
Vice President, Quality Management
University of Maryland Medical Center
Baltimore

Brent Reitz
President, Post-Acute Care Services
Adventist HealthCare Rehabilitation
Rockville

Nitza Santiago
Assistant Vice President, Quality
& Patient Safety
Sinai Hospital of Baltimore
Baltimore

Mitchell Schwartz, M.D.
Chief Physician Executive, Luminis Health,
and President, Luminis Health Clinical
Enterprise
Annapolis

Rahul Shah, M.D.
Senior Vice President, Hospital-Based
Specialties
Children's National Health System
Washington, D.C.

Neel Vibhakar, M.D.
Senior Vice President & Chief Medical Officer
University of Maryland Baltimore Washington
Medical Center
Glen Burnie

Julie Vitko*
Senior Director, Quality & Patient Safety
UPMC Western Maryland
Cumberland

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*Denotes new members

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COUNCIL ON CLINICAL & QUALITY ISSUES

Wednesday, July 24, 2024, 1:30 pm – 3:30 pm.
MINUTES

ATTENDANCE		
Members	***Present***	***Absent***
David Maine, M.D., Chair	x	
Michelle Martz, Vice Chair		x
Mohammed Shafeeq Ahmed, M.D.	x	
Laurel Brinkley	x	
John Chessare, M.D.	x	
Griffin Davis, M.D.	x	
Angela Green	x	
Kathryn Fiddler, DNP	x	
Heather Kirby		x
David Lang, M.D.		x
Ralph Lebron, M.D.		x
Stuart Levine, M.D.		x
Steven Michaels, M.D.		x
John Patrick, M.D.		x
Matthew Poffenroth, M.D.		x
Michel Anne Preas	x	
Brent Reitz.		x
Nitza Santiago.	x	
Mitchell Schwartiz, M.D.		x
Rahul Shah, M.D.		x
Neel Vibhakar, M.D.	x	
Julie Vitko	x	
Guests		
Nitza Santiago, Bonnie Arze, Dr. Nicole Rochester, Geeta Sood, Stephanie Peditto		
Attending MHA Staff		
Kelley Bender, Ahmed Elsayed-Ahmed, Sharon Metzler, Anene Onyeabo, Brian Sims, Amy Goodwin, Brian Burkhalter, Melony G. Griffith, Taylor Dotson, Tequila Terry, Felicia Hutchinson		

RY 2025 Performance and RY 2026 Quality Programs

Outcome
MHA reviewed rate year (RY) 2025 hospital quality performance and key issues discussed at the RY 2026 Quality Policies Webinar.

Main Points of Discussion
- Staff mentioned that the Health Services Cost Review Commission (HSCRC) is considering moving to attainment only for the Readmission Reduction Incentive Program (RRIP)
- While staff do not have a timeline for implementation, it was noted that the discussion will likely continue under the Advancing All-Payer Health Equity Approaches and Development (AHEAD) model. It was further noted that attainment targets would need to be increased by 5 to 7% up to a total of 11% to keep the statewide financial impact constant from the current policy
- MHA discussed members' HCAHPS performance and mentioned that HSCRC wants to partner on improving HCAHPS performance
- Members discussed the challenges and best practices related to improving HCAHPS performance
    - Challenges include delayed boarding, throughput, and low response rate
    - Best practices suggested include retraining hospital staff around patient satisfaction, nurse and leader rounding, bedside shift handoffs, changing survey administration approach to increase response rate e.g., phone calls instead of emails, getting to know me boards, etc.
- New policies for 2026 include:
    - Quality Based Reimbursement Program (QBR):
        - 50/50 split between inpatient mortality measure and 30-day mortality measure
        - Total follow-up after discharge: Medicaid, Medicare, and Medicare disparities (Patient Adversity Index)
        - Emergency department (ED) length of stay (LOS)
    - RRIP disparity:
        - Hospitals must submit interventions aimed at reducing within-hospital readmissions disparities
- Members suggested conducting analysis on mortality and readmissions

MHA Next Steps
- MHA will conduct and provide the following analysis:
    - Top HCAHPS performers and drivers of success
    - Correlation between declining readmissions and mortality
    - Readmissions disparity component performance trend

Member Action

- Contact Brian Sims with questions or feedback

Emergency Department Initiatives Update

Outcome
Council members were provided with an update on EDDIE performance metrics, the RY 26 ED LOS policy, and the launch of the ED Wait Time Reduction Commission. Members requested clarification on the definition of observation status for the ED LOS policy.

Main Points of Discussion
- In RY26, the QBR measure will have no risk-adjustment and no additional exclusion criteria as well as:
    - Be weighted at 10% of PCE domain (as voted on in the policy)
    - Be improvement only; improvement target range will be 5-10% compared to CY 2023
    - Include ED LOS for non-psychiatric admitted patients only
    - Not include hospital observation patients
    - Include ED observation, as defined by physical location of the patient
- Members questioned why the QBR measure has no risk-adjustment; staff responded that HSCRC was concerned that risk adjusting could mask performance or improvement opportunity
- The Council suggested that advocacy data be modified to align with HSCRC's data (presented during the June 21st meeting) on Skilled Nursing Facilities' capacity
- Staff noted that there will be staff representation on the ED Wait Time Reduction Commission's Hospital Best Practices Subgroup

MHA Next Steps
- MHA will continue to monitor HSCRC policies and the ED Wait Time Commission and advocate on behalf of the field as policies are developed and recommendations are made through the Commission
- MHA will conduct and/or provide the following analysis:
    - Year-over-year ED LOS measures in MD vs Nation

Member Action
- Contact Brian Sims with questions or feedback

Population Health Management – HSCRC Planning

Outcome
Staff provided an overview of the new HSCRC mandate on population health management and a summary of feedback from work group discussions.

Main Points of Discussion

- Hospitals will be required to submit population health management plans to HSCRC by the end of calendar year 2024. The plans should identify at least three conditions driving avoidable utilization, readmissions, and/or cost within hospitals
- HSCRC will classify population health management plans submitted by hospitals as "meets standards" or "does not meet standards." Those hospitals without plans that meet standards will have 0.19% in global budget revenue funding removed through a "claw back"
- HSCRC staff will also convene a Population Health Innovation Subgroup to discuss high-value care/plans, revenue for reform, and innovations in clinical delivery program
- The subgroup is accepting applications through the end of the week
- The Council noted that payers should have a role and accountability in the plans as they play a critical role in continuity of care e.g., prior authorizations and denials

MHA Next Steps

- MHA will continue working with members to develop advocacy positions on the plans and will share data with members as necessary to help inform these decisions

Member Action

- Contact Tequila Terry with feedback on the proposed language/ definition for population health management

ADJOURNMENT
There being no further business, the Council adjourned at 2:46 pm.

THESE MINUTES HAVE NOT YET BEEN APPROVED BY THE COUNCIL ON CLINICAL & QUALITY ISSUES

Topic	**Board of Trustees' Priorities & Quality Implications**
Objective	Review priorities for the hospital field identified by the MHA Board of Trustees and identity quality implications to support approaches to address the priorities
Discussion Questions	1. What are the quality implications associated with each of the BOT priorities? 2. Which of the HSCRC's Performance Measurement Work Group objectives most closely align with each BOT priority? 3. Are there quality or population health issues that should be prioritized that aren't reflected in the BOT priorities?

Board of Trustees' Priorities

The MHA Board of Trustees (BOT) and Group of 8 (G8) have communicated that for our hospitals to be successful in the current legislative and regulatory environment, the field needs to identify priorities, come to consensus on solutions, and advocate collectively. In response, MHA surveyed BOT and G8 members to select the top challenges affecting Maryland hospitals. Through this process, members identified three priorities that will guide MHA's advocacy efforts going forward:

- Payer denials and accountability
- Rising costs for essential physician coverage
- Policies to support the financial health of hospitals

MHA convened several member-led groups, including the Health Care Payment Work Group, Chief Medical Officer Network, Legislative Strategy Group, and Council on Financial Policy to discuss these priorities. Additionally, MHA held working sessions with BOT and G8 members to gather input on policy, regulatory, and legislative options/levers to advance each priority.

This discussion is intended to raise awareness of these priorities for Council members and align CCQI efforts with fieldwide priorities where feasible. Additionally, Council members will be asked to provide input on the priorities to ensure messaging includes quality and patient impact implications, bolsters MHA's advocacy, and better positions the field for success.

Prepared by: Brian Sims, Vice President, Quality & Equity

Attachment: MHA Board of Trustees Priorities – Quality Implications

MHA BOARD OF TRUSTEES PRIORITIES – QUALITY IMPLICATIONS

MHA BOARD-IDENTIFIED PRIORITIES

- MHA Board of Trustee members completed a field priority survey
- Identified three priority areas:
  - Payer Denials and Accountability
  - Rising Costs for Essential Physician Coverage
  - Financial Health of Hospitals
- Policy options/levers discussed in MHA work groups
  - Health Care Payment Work Group
  - Legislative Strategy Group
  - Chief Medical Officer Network
  - Council on Financial Policy
  - Board of Trustees

BOT PRIORITIES: FINANCIAL & QUALITY IMPLICATIONS

Payer Denials & Accountability

- What are the implications on quality, care, and/or access?
- Are denials associated with potentially avoidable utilization? Which data may support this?

Rising Costs for Essential Physician Coverage

- What are the implications on quality, care, and/or access?
- What is the most effective messaging for connecting the rising costs with critical hospital operations and improved patient outcomes and quality?

Financial Health of Hospitals

- What are the implications on quality, care, and/or access?
- What are quality-related risks of operating in a financially constrained environment for hospitals?

RY2025 TOTAL HOSPITAL QUALITY PERFORMANCE

Hospital Quality Program	% Potential Inpatient Revenue at Risk	% Realized Revenue at Risk	$ Realized Rewards	$ Realized Penalties	Net Revenue Adjustment
QBR	2%	-0.57%	$ 1,158,332	$ (68,222,204)	$ (67,063,872)
MHAC	2%	0.33%	$ 46,870,663	$ (8,674,977)	$ 38,195,686
RRIP*	2%	0.13%	$ 42,038,261	$ (27,383,273)	$14,654,988
Total Adjustment	**6%**	**-0.12%**	**$ 90,067,256**	**$ (104,280,454)**	**$ (14,213,198)**

* RRIP excludes the disparity gap

HSCRC RY 2027 QUALITY POLICIES: MAIN DECISIONS

1. **Quality-Based Reimbursement (QBR) Program**
   (Oct 24/Dec 24)
   - HCAHPS improvement framework
   - ED LOS Updates
   - Monitoring Digital Measures
2. **Maryland Hospital Acquired Conditions (MHAC) Program**
   (Feb 25/ April 25)
   - Payment PPCs
   - Small Hospital Concerns
   - Monitoring Digital Measures
3. **Readmissions Reduction Incentive Program (RRIP)**
   (Dec 24/ Feb 25)
   - Impact of ED revisits and use of observation status
   - Disparities modeling including observation stays
4. **Population Health**
   (Nov 24/ Jan 25)
   - Review IP diabetes screening pilot to inform potential policy recommendation
5. **Emergency Department/Multi-Visit Patient Policy**
   (Oct 24/ Dec 24)
   - Finalize measure as within MD or within system counts
   - Discuss how to incorporate into existing or new PAU policy
6. **ED-Hospital Throughput Best Practices**
   (Nov 24/ Jan 25)
   - Finalize best practices
   - Develop data collection
   - Develop methodology for scaling revenue adjustments

Dates on the left indicate draft policies; final policies are on the right.

DISCUSSION QUESTIONS

1. Which of HSCRC's Performance Measurement Work Group objectives most closely align with each of the BOT priorities?
2. Are there quality or population health issues that should be addressed that aren't reflected in the BOT priorities?

Maryland Hospital Association

Council on Clinical & Quality Issues

October 15, 2024

Topic	**Adverse Events Reporting**
Objective	To share an update on the Maryland Department of Health Office of Health Care Quality's (OHCQ) FY 2023 Adverse Events Report
Discussion Questions	1. What support is needed from OHCQ to facilitate improvement efforts? 2. What strategies have been implemented in your hospital to improve safety and mitigate adverse events?

OHCQ is expected to release the fiscal year 2023 report on adverse events in Maryland hospitals in the coming weeks.

The report is expected to be unfavorable to hospitals. Given this, MHA convened hospital subject matter experts to review a planned response strategy. These experts identified opportunities and risks and guided MHA's messaging on behalf of the field.

Under the Hospital Patient Safety Program, hospitals must identify adverse safety events and are expected to report "near misses." The Code of Maryland Regulations (COMAR), section 10.07.06.02B(2) defines an adverse event as an unexpected occurrence related to an individual's medical treatment and not related to the natural course of the patient's illness or underlying disease condition. Further COMAR 10.07.06.02B(8) defines a "near miss" as a situation that could have resulted in an adverse event but did not, either by chance or through timely intervention. The OHCQ adverse event report is made public and summarizes events that have occurred in hospitals statewide.

The report will describe three levels of events:

- Level 1: An adverse event that results in death or serious disability
- Level 2: An adverse event that requires a medical intervention to prevent death or serious disability
- Level 3: An adverse event that does not result in death or serious disability and does not require any medical intervention to prevent death or serious disability

MHA will discuss a proposed action plan that includes resources for members, public messaging, and proactive conversations with OHCQ leadership.

Prepared by: Tequila Terry, Senior Vice President, Care Transformation & Finance

Attachment: Adverse Events Overview Slides

MHA ADVERSE EVENT REPORT ACTION PLAN

MARYLAND HOSPITAL PATIENT SAFETY PROGRAM

- Maryland established the Maryland Hospital Patient Safety Program in March 2004 and is regulated under the Code of Maryland Regulations (COMAR)
  - COMAR 10.07.06.02B(2) defines an adverse event as an unexpected occurrence related to an individual's medical treatment and not related to the natural course of the patient's illness or underlying disease condition
  - COMAR 10.07.06.02B(8) defines a "near miss" as a situation that could have resulted in an adverse event but did not, either by chance or through timely intervention
- In Maryland, the Hospital Patient Safety Program describes three levels of events:
  - Level 1: An adverse event that results in death or serious disability
  - Level 2: An adverse event that requires a medical intervention to prevent death or serious disability
  - Level 3: An adverse event that does not result in death or serious disability and does not require any medical intervention to prevent death or serious disability

FY 2023 REPORT – EXPECTED CONTENT

- The MDH Office of Health Care Quality (OHCQ) is expected to release its latest adverse events report (timing TBD)

- The top 5 categories for adverse events are:
  - Hospital Acquired Pressure Injury (HAPI)
  - Falls
  - Delays in treatment
  - Retained Foreign Objects
  - Medication Errors

RISKS & OPPORTUNITIES

MHA convened adverse event subject matter experts to identify concerns & opportunities to inform our advocacy

Risks	Opportunities

• Need clarification on the purpose of data collection (regulatory oversight vs. quality improvement)
• Recent issues with OHCQ oversight of nursing homes may prompt more interest in increased regulatory oversight
• Highlighting staffing shortages as a contributor could bolster unionization efforts
	• OHCQ collaboration on solutions is needed
	  • How can "Root Cause Analysis" data be used to drive statewide change?
	• Historically the report tone is overly negative
	  • OHCQ should provide context about how the number of adverse events compares as a percentage of all services
	  • Provide advance notice on the report contents to MHA and/or Maryland Patient Safety Center
	• A communications strategy is needed
	  • Proactively engage the press to help shift the perception
	  • Draft a message about hospitals' commitment to safety for patients
	  • Consider engaging a crisis management firm
	• Partnership with Maryland Patient Safety Center can help
	  • Given their clinical resources and strong relationship with OHCQ, consider ways to partner

PROPOSED MEDIA TALKING POINTS

- **Talking points are intended not to challenge the results but to change the conversation:**

- **Maryland is unique**
  - Maryland is one of 27 states nationally with extensive reporting requirements for adverse events
  - We're under more oversight, we practice more transparency, and we have strong systems in place to identify events and remedy them.
  - Reporting in Maryland is encouraged, robust, and part of the innovative strategy to improve quality and safety

- **Results should be put into perspective**
  - During the pandemic, hospitals experienced increased rates of adverse events due to the high volume of patients and the strain on the healthcare system
  - Hospitals are increasingly caring for older patients with more complex health needs which creates a propensity for things like falls and pressure injuries
  - There was a clarification and expansion in the way some adverse events were self-reported which resulted in more events being reported.
  - Fortunately, adverse events are a rare occurrence across the 4.6 million patient encounters each year.

- **Hospitals are committed to patient safety and transparency**
  - Maryland hospitals have a strong culture of patient safety and transparency to identify these issues, which can result in perceived higher instances of adverse events in our region compared to other states that do not report
  - These adverse events are self-reported. Maryland hospitals track these events to understand them, address concerns, and prevent them in the future.
  - Reporting of adverse events should be supported as part of our state's goal to have a highly reliable health care

MHA ACTION PLAN

- Identify adverse events media spokespeople
  - Partner with Maryland Patient Safety Center and hospital subject matter experts on media engagement
- Speak to reporters to provide education on the hospital perspective before the report is released
  - Continue conversations with Washington Post Reporter (Katie Shepherd)
  - Additional reporters as needed
- Prepare a press release to be distributed when the report is released
- Prepare talking points and work with AHA to ensure a consistent message
- Conduct "quiet conversations" with OHCQ acting leadership (Nilesh Kalyanaraman)
  - Advocate for increased collaboration on improvement strategies and feedback on root cause data the is submitted by hospitals
  - Request additional data sharing and interim/advance copies of report

DISCUSSION QUESTIONS

1. What support is needed from OHCQ to facilitate improvement efforts?

2. What strategies have been implemented in your hospital to improve safety and mitigate adverse events?

Topic	**Emergency Department (ED) and Hospital Throughput Policy Update**
Objective	To share the latest HSCRC developments related to the ED length of stay (LOS) and ED Best Practices Incentive policies and gain member feedback on current and expected activities related to ED LOS and hospital throughput performance improvement to shape advocacy on behalf of the field
Discussion Questions	1. What guiding principles should steer our advocacy on the Best Practices Incentive policy? 2. What should be the field's key messages at the Wait Time Reduction Commission?

The Health Services Cost Review Commission (HSCRC) staff is developing several hospital payment policies and preparing to launch the Emergency Department Wait Time Reduction Commission. MHA will update Council members about this work and the associated challenges and opportunities.

Emergency Department Wait Time Reduction Commission

HSCRC staff will facilitate the Commission, which will address factors throughout the health care system that contribute to increased emergency department wait times. The Commission's areas of focus are reducing the number of people who need the emergency department (ED), improving throughput within the hospital, and improving the hospital discharge process and post-ED community resources. The first meeting of the Commission is Oct. 23. MHA will update members on key discussion topics in future meetings.

Emergency Department Best Practices Incentive Policy

HSCRC staff convened a subgroup of hospital members and other subject matter experts to develop a payment policy incentivizing hospitals to adopt three- to five-evidence-based practices to improve ED length of stay (LOS) and hospital throughput. The subgroup will develop hospital best practices and scoring criteria, advise on revenue at-risk and scaled financial incentives constituting up to +/- 1% revenue adjustment, and provide input on data collection and auditing. Staff will present a draft policy at the November Commission meeting and a final draft in January.

Emergency Department Length of Stay Policy

In 2023, HSCRC commissioners approved the development of an ED LOS policy for admitted patients to be incorporated in the Quality-Based Reimbursement (QBR) program. Over the past year, HSCRC staff worked with the field to develop a policy that is weighted at 10% of the overall QBR score. Staff is proposing tiered scoring with a performance threshold of 0% improvement and a benchmark of 5% improvement for hospitals currently performing below the

statewide median LOS. For hospitals performing above the statewide median LOS, staff agreed on a 0% improvement threshold and a 10% improvement benchmark. Revenue adjustments for calendar year 2024 performance on the ED LOS policy are expected to be applied to the rate year 2026 QBR revenue adjustment.

Member feedback on guiding principles to improve ED LOS, overall hospital throughput performance, and the field's position on the Best Practices Incentive Policy will inform advocacy efforts to support effective solutions.

Prepared by: Brian Sims, Vice President, Quality & Equity

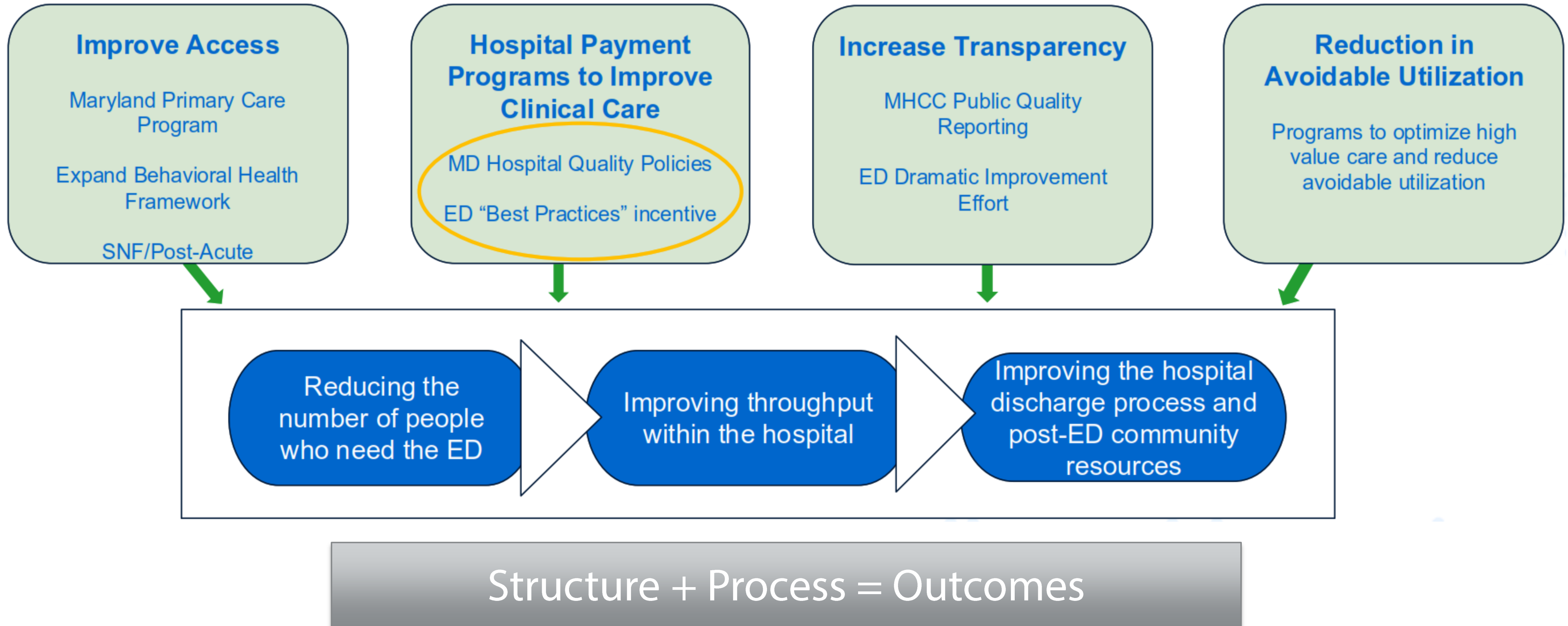
Attachment: Emergency Department LOS and Hospital Throughput Slides

ED LENGTH OF STAY AND HOSPITAL THROUGHPUT POLICY UPDATE

OVERVIEW:
MARYLAND ED WAIT TIME REDUCTION COMMISSION

- **Purpose:** To address factors throughout the health care system that contribute to increased emergency department wait times
- **Specific focus:** Develop strategies and initiatives to recommend to state and local agencies, hospitals, and health care providers to reduce ED wait times, including initiatives that:
  - Ensure patients are seen in most appropriate setting
  - Improve hospital efficiency by increasing ED and IP throughput
  - Improve post-discharge resources to facilitate timely ED and IP discharge
  - Identify and recommend improvements for the collection and submission of data
  - Facilitate sharing best practices
- Kick-off meeting is **Oct. 23, 2024**

ED WAIT TIME REDUCTION COMMISSION



COMMISSION MEMBERS

- **Chairs:**
  - Secretary of Health – **Laura Herrera Scott, MD, MPH**
  - Executive Director of HSCRC– **Jon Kromm, PhD**
- **Appointed Members:**
  - Executive Director of MIEMSS – **Ted Delbridge, MD**
  - Executive Director of MHCC (representative) – **Wynee Hawk, RN, JD**
  - 1 individual with operation leadership experience in an ED (physician) – **Dan Morhaim, MD**
  - 1 individual with operation leadership experience in an ED (physician) – **Neel Vibhakar, MD**
  - 1 individual with operations leadership experience in an ED (non-physician or APP) – **Barbara Maliszewski, RN**
  - 1 representative from local EMS – **Danielle Knatz**
  - 1 representative from a Managed Care Plan – **Amanda Bauer, DO**
  - 1 representative of Advanced Primary Care Practice – **Mary Kim, MD**
  - **1 representative from MHA – Andrew Nicklas, JD**
  - 1 representative from a patient advocacy organization – **Toby Gordon, ScD**
  - 1 representative of a behavioral health provider – **Jonathan Davis, LPC**

DISCUSSION QUESTION

1. What should be the field’s key messages at the Wait Time Reduction Commission?

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ED BEST PRACTICES INCENTIVE POLICY DEVELOPMENT

Policy Goal:

- Develop process or structural measures that will address systematically longer ED length of stay (LOS) in the state
- Promote adoption of 3-5 hospital best practices by providing GBR financial incentives
- Align hospital initiatives with the goals of the ED Wait Time Reduction Commission

Subgroup Purpose:

- Develop hospital best practices and scoring criteria to improve overall hospital throughput and reduce ED length of stay
- Advise on revenue at-risk and scaled financial incentives
- Provide input on data collection and auditing

Timeline:

- Draft Policy: November 2024
- Final Policy: January 2025

SCORING EXAMPLE: PERFORMANCE IMPROVEMENT COMMITTEE

Structural Best Practice: convene a Hospital Throughput Performance Improvement Committee

Develop Set of Criteria for Assigning Differential Points

Elements	Full Points	Partial Points	Minimum Points
Frequency of Meetings	Weekly	Monthly	Quarterly
Composition of Committee	Multidisciplinary	X% front line workers	Leadership
Written Meeting Agendas and Minutes	Written agendas	Written minutes	
Established Goals	1-2 Goals	3-4 Goals	SMART Goals
Data for Tracking Goals & Frequency	Yes	Monthly	Quarterly
Other Actions?	QI cycles?	New Protocols?	

This is placeholder. Subgroup would need to decide how often they should meet (i.e., monthly could be full points) and other elements

Data: Hospitals could provide meeting agendas, redacted minutes, goals, and tracking data.

NEXT STEPS

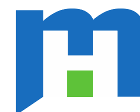
At the Oct. 11 meeting, the subgroup will:

- Review/discuss literature to support selected measures
- Develop recommended menu of options for best practice process/structure measures
- Discuss scoring criteria for elements of each best practice process/structure measure
- Discuss the timeline for implementation vs. measurement periods
- Discuss revenue at risk and potential "ramp-up" model

DISCUSSION QUESTION

1. What guiding principles should steer our advocacy on the Best Practices Incentive policy?

ED LENGTH OF STAY MEASURE UPDATE



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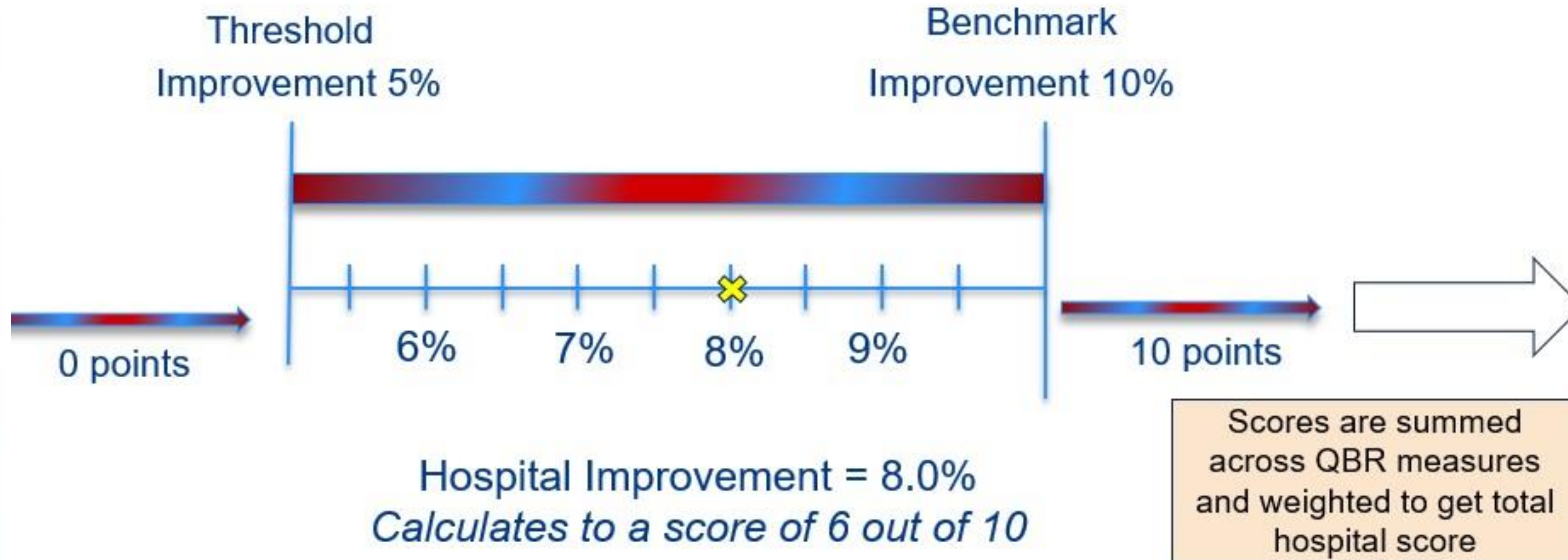
QBR ED LOS POLICY

- Incentive measures improvement from CY 2023 to CY 2024
- **Measure:** Percent change in the median time from ED arrival to physical departure from the ED for patients admitted to the hospital
- **Population:** All non-psychiatric ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period
- **Scoring:** Use attainment calculation for percent change to convert improvement into a 0 to 10 point score (see next slide)
- **Data:** Ad hoc data submissions of time stamps to merge in with case-mix data
- **Statewide Goal:** TBD by ED Wait Time Reduction Commission

QBR PERFORMANCE STANDARDS

Performance Standard Options:
Option 1: Set 5% threshold and 10% benchmark for all hospitals (example below)
Option 2: Tier threshold and benchmark based on CY 2023 performance (best 1/3rd of hospitals: 0-5%; middle 1/3rd: 5-10%; lowest 1/3rd: 10-15%



QBR Revenue Adjustment Scale

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	80%+	2.00%

TIERED PERFORMANCE STANDARDS MODELING

ED LOS in Minutes

1200
1000
800
600
400
200
0

Threshold = 0%
Benchmark = -5%

Below Median

Above Median

Threshold = 0%
Benchmark = -10%

210061 210017 210001 210039 210028 210024 210057 210032 210044 210065 210022 210027 210005 210034 210056 210019 210023 210035 210051 210004 210033 210015 210060 210008 210063 210011 210062 210018 210049 210038 210048 210040 210002 210009 210043 210003 210012 210029 210037

Base state median = 523 minutes

If hospitals improve to respective benchmarks, state median=491 minutes.

Net change in $ with EDDIE proxy vs. No ED	June 23 -June 24 Rolling 12 month improvement
$104,344	-3.37%
$79,129	-6.06%
$189,153	-2.16%
-$205,250	3.53%
$422,442	-9.33%
$765,717	-3.81%
-$128,418	10.64%
-$108,678	5.58%
-$203,916	2.18%
$127,060	-1.73%
-$249,947	0.85%
-$76,092	-0.21%
$1,074,354	-14.35%
$517,700	-14.05%
-$95,749	6.24%
$1,048,810	-4.19%
-$424,056	6.93%
-$59,016	0.39%
$688,044	-19.88%
$39,741	-0.19%
-$78,684	12.36%
$913,670	-7.54%
$110,749	-5.73%
$867,077	-19.48%
-$336,309	5.15%
-$140,066	5.58%
$176,829	-1.66%
$390,751	-26.44%
-$100,562	25.46%
$248,156	-6.50%
-$149,850	13.19%
$676,050	-12.06%
-$567,781	-1.03%
$1,362,173	-4.66%
$65,292	-1.51%
$451,207	-4.55%
$1,855,384	-8.09%
-$364,138	12.18%
$59,966	-1.32%
$925,307	-17.74%

DISCUSSION QUESTION

1. What considerations should be made for the ED LOS policy for RY27?

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