ED-Hospital Throughput Best Practices

Jan 30, 2025

maryland health services cost review commission

Agenda

- Update on ED LOS Preliminary Data Submission
- Update on ED Wait Time Reduction Commission & Subgroups
- Review Best Practice Measure/Tier Submissions from small group
- Next Meeting Feb 27th & final best practice measures/tiers need to be submitted by COB on Feb 28th

ED LOS Measure Data Submission

- As of January 17th, all hospitals submitted prelim data through December 2024
- This was the first case mix data submission, as opposed to monthly ad hoc data submission.
- Several hospitals have some issues with capture of arrival times, these are flagged as “warnings”, but will be classified as errors during the next submission
- Final data submission is due by March 3, but ad hoc file is submission can occur if hospitals want to evaluate prelim data prior to March.

ED Wait Time Reduction Commission:

Collaborate on behavioral health, post-acute, primary care, and other areas of opportunity.

Improve Access

Maryland Primary Care Program

Expand Behavioral Health Framework

SNF/Post-Acute

Implement Hospital Payment Programs to Improve Clinical Care

MD Hospital Quality Policies

ED "Best Practices" Incentive

Increase Transparency

MHCC Public Quality Reporting

ED Dramatic Improvement Effort

Reduce Avoidable Utilization

Programs to optimize high value care and reduce avoidable utilization

Reducing the number of people who need the ED

Improving throughput within the hospital

Improving the hospital discharge process and post-ED community resources

Increasing Transparency

Workforce Issues

maryland

Commission Subcommittees

Access to Non-Hospital Care

- Integrate and optimize best practices and data analytics for advanced primary care, specialty care, home health, post-acute care, and ancillary services in an effort to reduce avoidable ED and hospital utilization and improve care transition workflows throughout the continuum of care.
- Meetings every six to eight weeks.

Data Subcommittee

- Identify different data sources across healthcare platforms to include ambulatory, acute care, post-acute care, and third-party data.
- Meetings every six to eight weeks.

ED Hospital "Throughput" Incentives

- Develop a set of 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, and provide input on data collection and auditing.
- Meetings every four weeks.

Hospital Capacity, Operations & Staffing

- Subgroup will convene in April 2025.
- Planned focus of the subgroup is to assess access and capacity across the State, collaborate with commercial payers, Medicare, and Medicaid, and optimize workforce development opportunities.
- Meetings every four to six weeks.

Key Priorities

- **Key Priority Identified: Hospital Throughput & ED Boarding**
- Staff are focusing on the following key drivers impacting hospital throughput & ED boarding:
  - **Optimize capacity across the continuum of care (ambulatory, acute, post-acute, and community resources)**
  - **Care transitions within the hospital that impact length of stay (best practice subgroup focused on these efforts)**
  - **Care transitions to post-acute levels of care, inclusive of skilled nursing, palliative care, and home health**

Data Analysis Priorities

Our first step will be to analyze data by region and for hospital-specific factors, by hospital, possible, develop data-driven interventions that address the root causes identified by region and by hospital. Our areas of focus will be:

Primary care and BH capacity:

- Build upon primary care access study from MHCC
- Request data from MDPCP
- Request data from Behavioral Health workgroup

Hospital capacity:

- Occupancy at each hospital as defined by the following denominators:
- # of licensed beds
- # of physical beds
- # of staffed beds
- Bed type and distribution
- Length of stay (LOS), stratified by:
- patients discharged to home
- patients discharged to another facility/post-acute

In both of the above buckets, if possible, we will evaluate/quantify the impact of:

- payer type
- hospital operational throughput
- post-acute care transition delays (authorizations, denials, waiting for bed, refusal due to acuity)
- payer denials delays (not related to post acute)
- palliative care opportunity

Best Practices for Review and Discussion

Interdisciplinary Rounds

Tier 1: Interdisciplinary Rounds piloted with a target of x% on at least 1 unit

Tier 2: Interdisciplinary Rounds implemented on X additional units AND documentation of discharge planning initiated Day 1

Tier 3: Leadership involvement in Interdisciplinary Rounds

OR

Documentation of prior auth for post-acute placement by x timeframe; specialist consults completed within 24 hours of order, etc.

Bed Capacity Alerts

Tier 1: Bed capacity Alert triggered at a certain surge level, alert goes to all inpatient and outpatient areas And triggers mandatory leadership huddles

Tier 2: Bed capacity alert includes non-hospital partners (outpatient providers, local post-acute facilities)

Tier 3: Leverage Access centers and CRISP to facilitate most appropriate patient placement; potentially partner with MIEMSS long-term

Standard Daily Shift Huddle Proposal

- The AHRQ defines a huddle as a short, standing meeting that is typically used in clinical settings to quickly share important information and touch base with a team, typically held at the beginning of each workday or shift. This subgroup was tasked with building tiers for consideration as well as to present any barriers or opportunities identified by the group. Proposed tiers are defined below
  - **Tier 1:** Implementation of, at minimum, daily unit huddles utilizing a multidisciplinary team approach with a focus on throughput and discharges.
  - **Tier 2:** Tier 1 requirements with the addition of a standardized infrastructure (standard scripting, documentation, and/or use of huddle boards). Tier 2 would also include an escalation process for addressing clinical and/or non-clinical barriers to discharge or throughput.
  - **Tier 3:** Tier 1 and Tier 2 requirements, with the addition of monitoring and reporting of key performance indicators (KPIs) as drivers of process improvement r/t throughput. Example KPIs could include but are not limited to, percentage of huddle completion, percent of discharge orders written by noon, or percent patients leaving the facility by a designated time as determined by each facility.

NOTE: Group discussion relating to barriers to tiers included the consideration of ensuring each facility can operationalize these metrics to best fit their organizational needs. A global approach to tier development is supported to limit the need for additional resources and financial burdens on organizations as well as provides each organization the ability to customize their approach to drive performance specific to their demographics and population.

Expedited Care Bucket

Proposal 1: select one or more of multiple expediting practices:

Nurse expediter

Tier 1: Designated RN for admission/discharge planning/coordination
Tier 2: Tier 1 & x% decrease in discharge order to discharge time for D/C to Home pts
Tier 3: Tier 1 & 2 plus (x+5% decrease in discharge order time for D/C to Home

Discharge Lounge

Tier 1: Designated clinical space & staff to discharge patients from a Discharge lounge
Tier 2: Tier 1 & (x%) decrease to discharge order to discharge time
Tier 3: Tier 1, 2 & (x+5%) decrease in discharge order to discharge time

Observation Unit

Tier 1: Dedicated clinical space and staffing for short stay patients
Tier 2: Tier 1 & Decrease in Total Obs (ED Obs & Hospital Obs) LOS
Tier 3: Tier 1 & 2 & (x+5%) Decrease in Total Obs LOS

Expedited Care Bucket

Proposal 2:

- Develop/ implement processes & specific metrics
- Mandatory sharing across hospitals and reporting to HSCRC
- Define targets over CY25 in order to prevent unintended consequences

***Still need processes and specific measures for Proposal 2; targets could be defined over CY25 as the process develops and data is collected

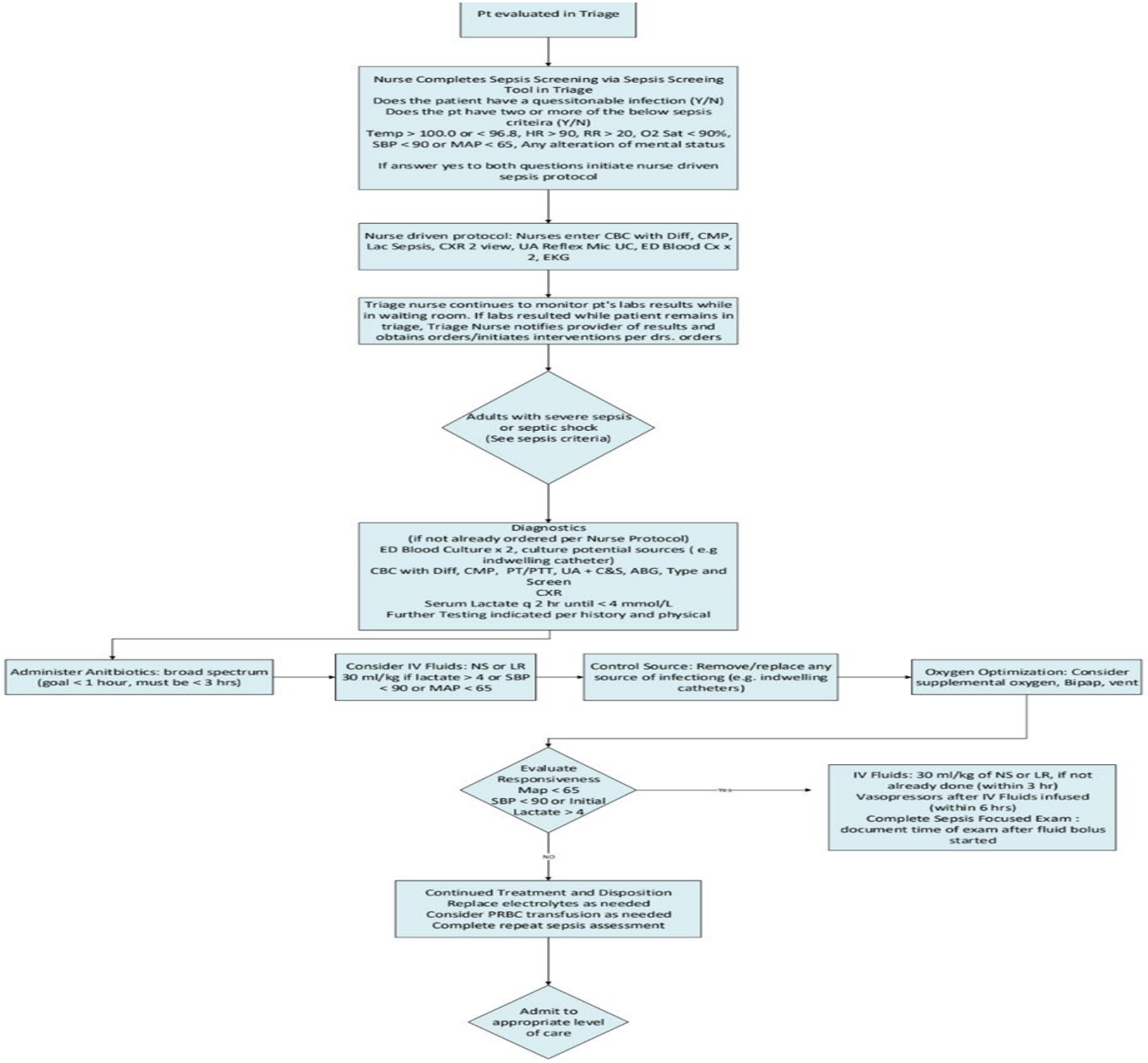
Clinical Pathways/Observation Management

Proposal 1

- **Example:** An outpatient TIA clinic established with a neurology group to see patients the next day for patients presenting with signs/symptoms of mild TIA.
- **Example**: Chest pain protocol that leverages nurse driven protocol and/or expedited evaluation in an outpatient setting if clinically appropriate & expedited protocol for inpatients.

- **Tier 1:** Design and implement the intervention
- **Tier 2**: Develop the data infrastructure to track and trend the obs/input vs ambulatory management of the target group of patients
- **Tier 3:** Demonstrate improvement (will need to define target)

Clinical Pathways/Observation Management—Proposal 2



Cristeria for Severe Sepsis or Septic Shock
Severe Sepsis = All 3 Criteria

Cristeria 1:
Suspected or Actual Infection

Criteria 2:
Systemic Inflammatory Response Syndrome
Any two of the following:
Temp < 36.0 or > 38.3
Pulse > 90/min
Respiratory Rate > 20/min,
WBC < 4,000 or > 12,000 or > 10% bands

Critiera 3:
One New Organ Dysfunction
Systolic Blood Pressure < 90 or Map < 65
Lactate > 2.0 (if Lactate > 4.0 should be treated as septic shock)
Acute need for Bipap or Vent
New Creatinine > 2.0
Total Bilirubin > 2.0 (non-ESRD)
Platelets < 100K

Tier Structure

Tier 1: Sepsis screening completed by nurse in Triage

Tier 2: Tier 1 + Nurse driven protocol initiated in triage if patient screened positive for sepsis

Tier 3: Tier 1 + Tier 2 + if critical values are resulted while pt remains in triage, Triage nurse notifies provider of abnormal results from sepsis protocol

Patient Flow/Throughput Council

Proposal 1

- Daily Safety / Capacity Morning Huddle
  - This meeting should be daily, be multi-D, focused on safety & capacity, and should begin with ED Boarding status and Nursing Unit staffing
- Review of automated Hospital Capacity Dashboard
  - Dashboard should pull data from EMR, hospital leadership should review capacity, occupancy, and resources
- Daily Afternoon ED Flow Meeting
  - Should focus on ED Volumes, Hospital Throughput, and potential discharges / other flow opportunities
- Observation Unit
  - This unit should take patients directly from the ED, based on well-defined inclusion & exclusion criteria
- Discharge Lounge
  - This discrete unit should facilitate movement of patients that are ready for DC (creates inpatient bed capacity)

***Need to assign these activities to tiers

Patient Flow/Throughput Council

Proposal 2

Tier 1: Established Patient Flow Throughput Performance Council with front-line and leadership representation, meets at least monthly

Tier 2: Council tracks and implements specific interventions targeted at decreasing inpatient LOS

Tier 3: Leadership has strategic goals for each department tied to patient flow throughput

Next Steps

- Comment Letters Due by 2/19
- Small groups will finalize Best Practice Tiers prior to 2/27 meeting so we can review and make any final edits during the 2/27 meeting
- Next Meeting 2/27, 9-11
- Final Draft Best Practices Policy with the final edits due to HSCRC Commissioners for review on 2/28
- Presentation of Final Policy at HSCRC Commission meeting on 3/12