maryland
health services
cost review commission

Emergency Department Subgroup 2:
ED-Hospital Best Practices Policy Development

9/27/2024

Agenda

- Overview of Emergency Department Wait Time Reduction Commission
- Best Practices Incentive Policy
  - Goal of policy and Subgroup Purpose
  - Potential Best Practices
  - Data Collection and Methodology for Revenue Adjustments
  - Next Steps
- ED QBR Performance Standards and Data Collection Updates

Establishment of Maryland ED Wait Time Reduction Commission

Bill went into effect July 1, 2024, and terminates June 30, 2027

Annual Reports due Nov 2025 and Nov 2026

Initial Meeting: October 23, 2024

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 of best practices*

Commission Appointed 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–**Wynee Hawk, RN, JD**
- ❑ 1 Indiv. with operation leadership experience in an ED (physician)–**Dan Morhaim, MD**
- ❑ 1 Indiv. with operation leadership experience in an ED (physician)–**Neel Vibhakar, MD**
- ❑ 1 Indiv 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**

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

Hospital Payment Programs to Improve Clinical Care

MD Hospital Quality Policies

ED "Best Practices" incentive

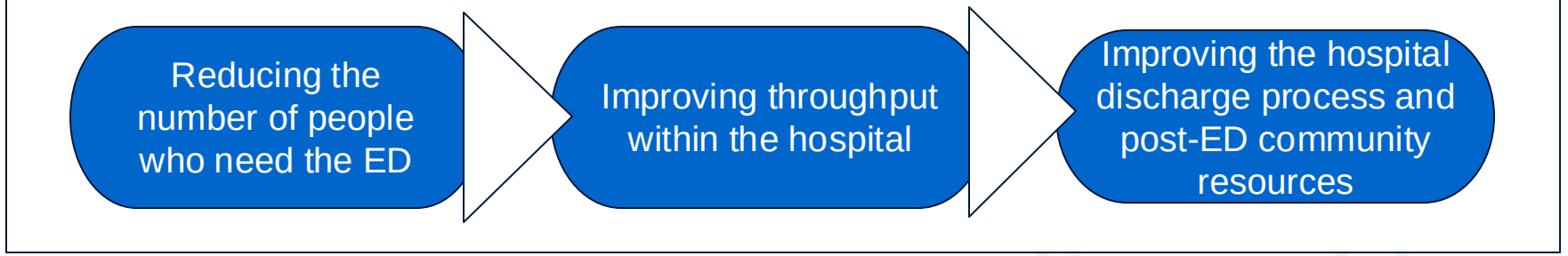
Increase Transparency

MHCC Public Quality Reporting

ED Dramatic Improvement Effort

Reduction in Avoidable Utilization

Programs to optimize high value care and reduce avoidable utilization



ED-Hospital Best Practices Policy Development

ED Best Practices Incentive Policy Development

Draft Policy November 2024
Final Policy January 2025

Commission leadership directive: Identify 3-5 best practice measures that will constitute a +/- 1% revenue at risk program for CY 2025 performance.

Policy Goal:

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

Subgroup Purpose:

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

Real Opportunity for Paradigm Shift

ED Commission State Initiatives

Primary Care

Post-Acute Care

Hospital Initiatives

Reducing the number of people who need the ED

Improving throughput within the hospital

Improving the hospital discharge process and post-ED community resources

Structure + Process = Outcomes

Access

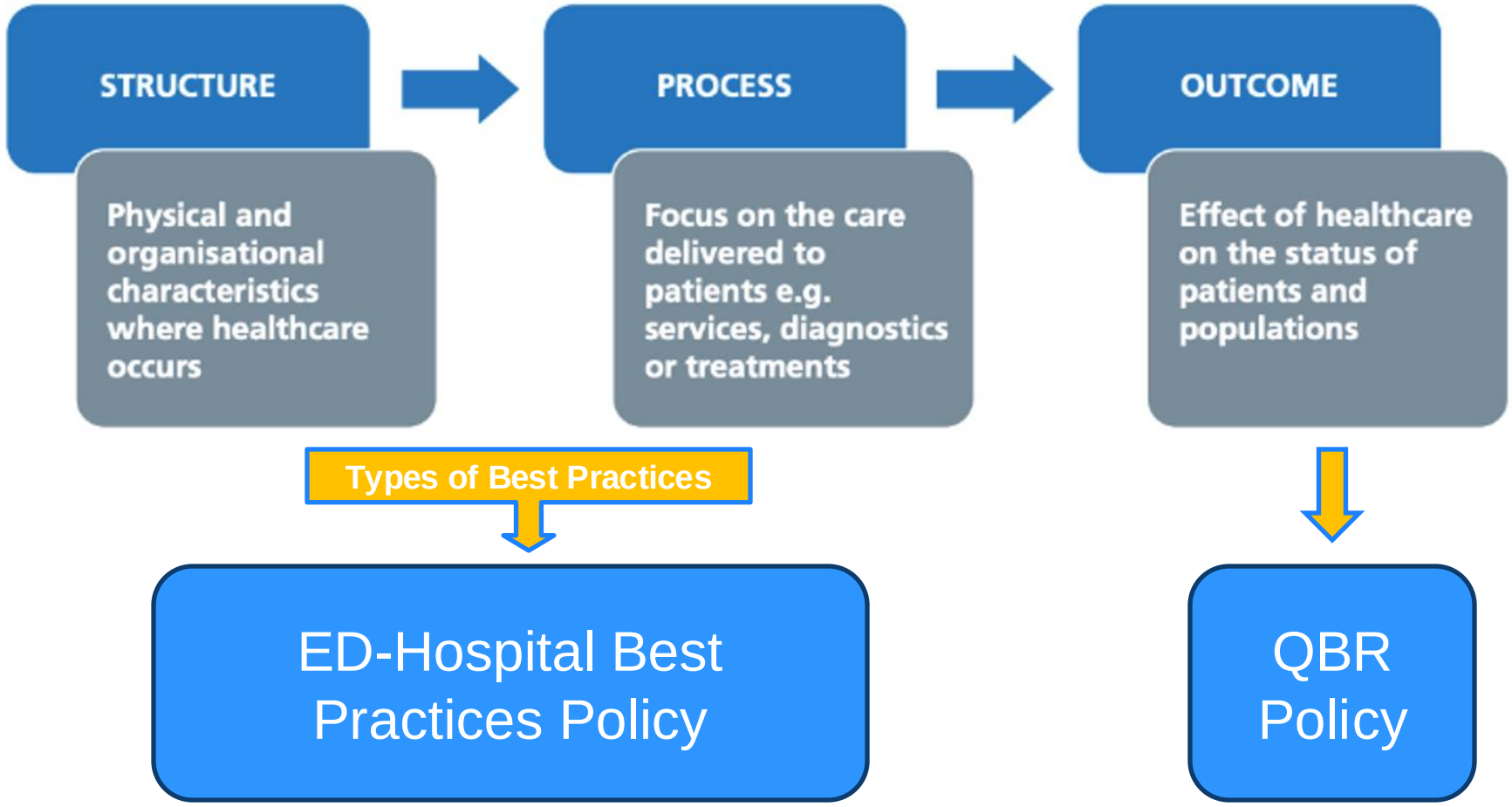
Capacity

Behavioral Health

Population Health

Health Equity

The Donabedian Model for Quality of Care



ED-Hospital Best Practices

Propose: Drop Down Menu with Measures —each hospital selects 3?
Complete list of recommendations is in attached word document for discussion/review
Measures on this slide are examples of measures we would like to highlight for further discussion

- **Care Management/Care Transition Interventions**
  - Number of case management interventions inpatient—set targets with point allocations
  - Case management staff available inpatient 7 days per week ? —set target ranges with point allocations
  - Case management availability in ED?
- **Capacity Alerts**
  - Inpatient only alerts
  - Inpatient and outpatient areas
  - Alerts and leadership huddles triggered
- **Hospital Throughput Performance Improvement Committee-**outlined on next slide, includes data transparency with staff
- **Inter-Disciplinary Rounds**
  - Process Implemented—x points
  - Interdisciplinary rounds occur with x frequency (95% compliance-x points, 85%-y points)
- **Early Discharge Time Targets (i.e., discharge by noon)**--set target ranges with point allocation (i.e., 75% + x points, 65-74% y points)
  - Could this include LOS team huddles/case reviews in some capacity?
- **Standardized Daily or Shift Huddles-use of huddle boards or similar tools, include ED Boarding numbers & wait time**

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

- Next meeting October 8th where we will review:
  - Review/discuss literature to support selected measures
  - Develop recommended menu of options for best practice process/structure measures
  - Scoring criteria for elements of each best practice process/structure measure
  - Timeline for Implementation vs. Measurement periods
  - Discuss revenue at risk and potential "ramp-up" model

ED QBR Performance Standards and Data Collection Update

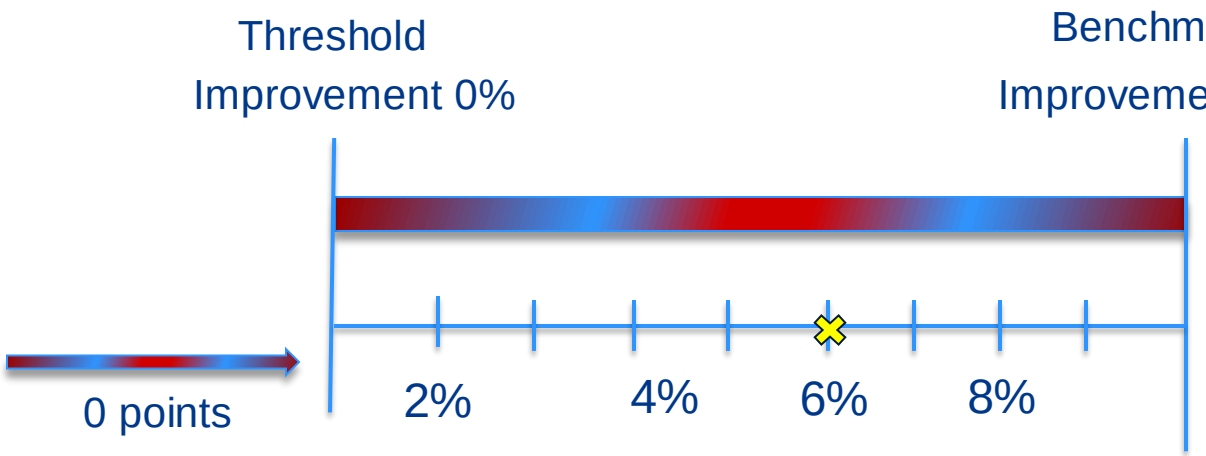
QBR Policy Approval and ED LOS Measurement Development Timeline

- 11/8/2023 QBR Draft Policy: Proposed options for inclusion of ED LOS measure
- 12/13/2023 QBR Final Policy: Approved inclusion of ED LOS measure at 10 percent weight
- Commission discussion:
  - QBR ED LOS Measure Development plan was proposed on January 10,2024
  - QBR ED LOS Measure Development Plan was reviewed on February 14, 2024
  - Commission meeting materials: Commission-Meetings (maryland.gov)
- Subgroup Meetings:
  - ED Subgroup 1 (Data): February 2nd, 2024, March 1st, 2024, April 12th,2024
    - ED LOS Data Submission Memo was sent via email to hospitals on May 20, 2024
    - ED LOS Data Submission Dates: Extended to September 13, 2024 (CY2023 and Jan-Mar 2024 data), December 16, 2024 (Apr-Sept data), March 2025 (Oct-Dec data)
  - ED Subgroup 2 (Incentive): April 26th, 2024, May 17th, 2024, June 21st, 2024, September 10, 2024
  - Meeting recordings and slides: Subgroup ED LOS Measure (maryland.gov)

QBR ED LOS Incentive CY 2024

- 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 Scoring Example



Hospital Improvement = 6.0%

Calculates to a score of 6 out of 10

Scores are summed across QBR measures and weighted to get total hospital score

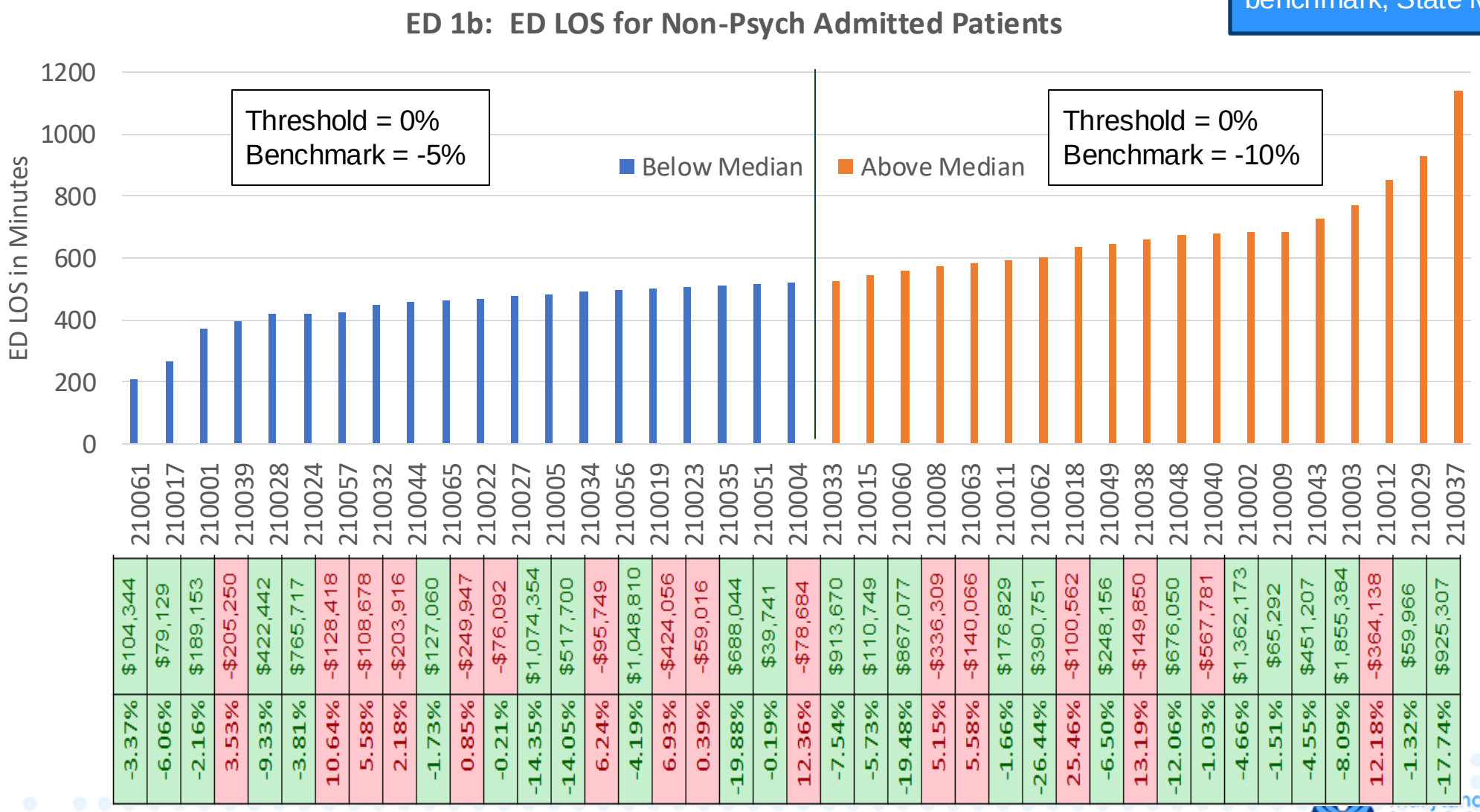
QBR Revenue Adjustment Scale

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%

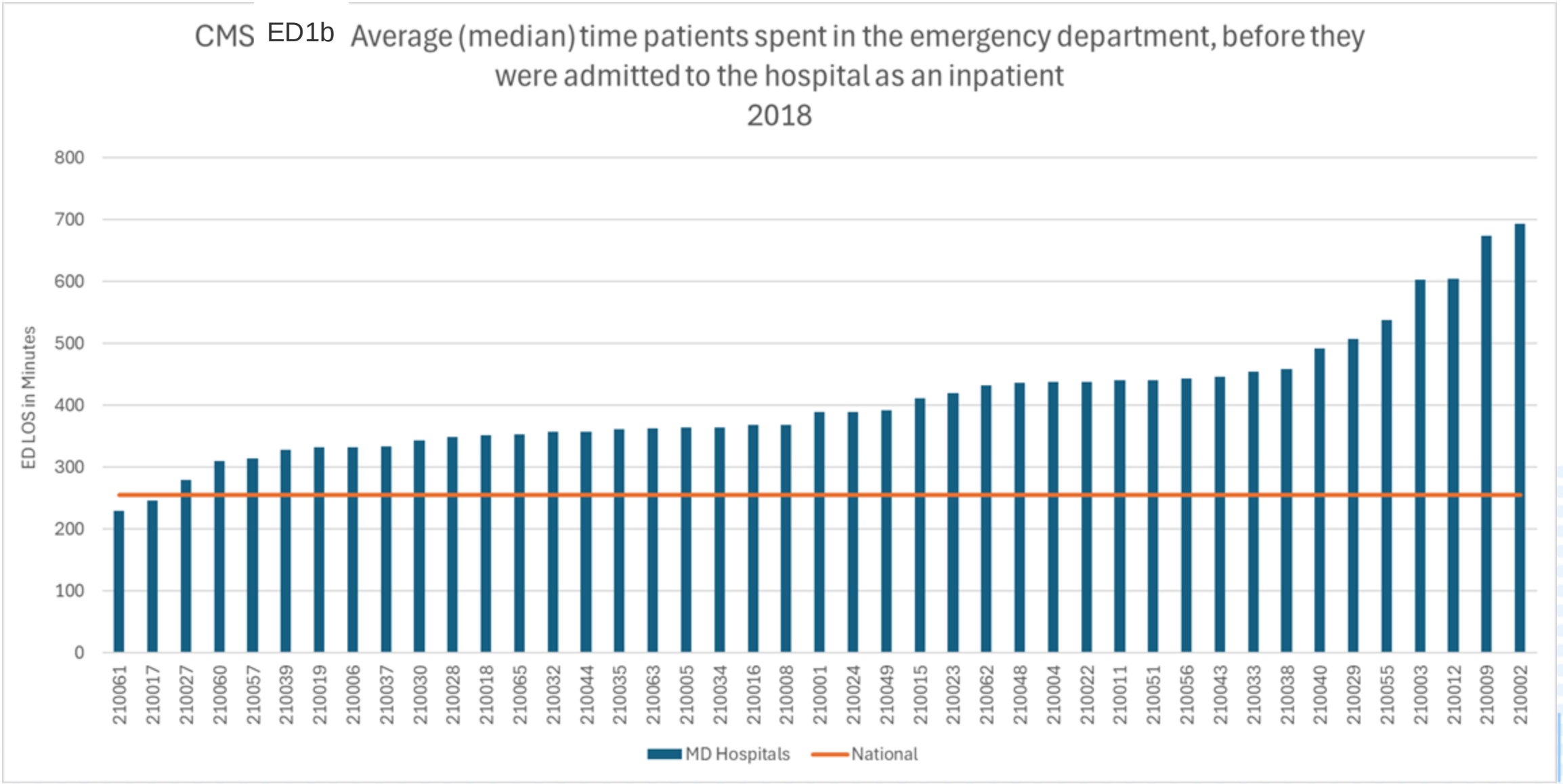
Current Proposal

Base State Median: 523

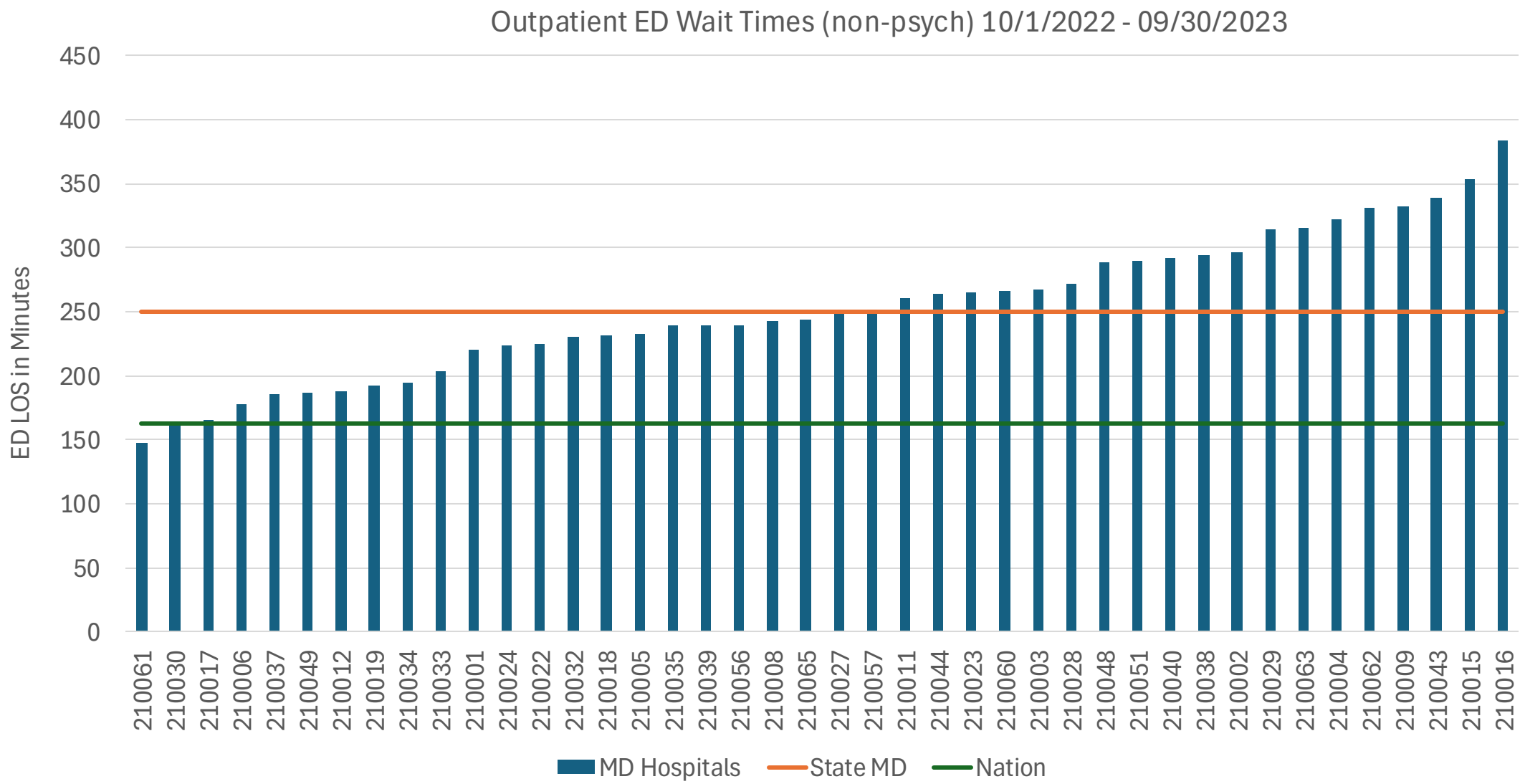
If all hospitals improve to benchmark, State Median: 491



Maryland vs. National Comparison: Older Data



Outpatient ED LOS (more recent data)



CY25 Recommendations to Consider

- RY2027 Draft QBR will be presented at October Commission Meeting
- Staff are proposing the following for subgroup input:
  - Include ED1b in QBR PCE Domain at 10 percent of QBR (same weight)
  - Maintain improvement
  - Develop risk-adjusted ED LOS measure for attainment to be monitored or retrospectively adopted
  - Set improvement standards based on Statewide Improvement Goal established by ED Wait Time Reduction Commission
    - Base year: Cumulative improvement from 2023 vs. Year over Year improvement.
    - Tiers: Recommend if improvement only
  - Consider treating observation stays (23+ hrs?) as inpatient admissions
  - Other inclusion/exclusion criteria?

QBR ED LOS Data Collection Update

- Deadline to submit patient level data was extended to 9/13
- HSCRC staff and hMetrix are followed up with hospitals with low match rates between the adhoc ED LOS data file and case mix data. Reasons for lack of matches includes:
  - Difference in admission dates
  - Patients who came to ED but Left without Being Seen do not have case mix data
  - Duplicates
  - Truncated MRNs
- Based on findings some hospitals re-submitted before deadline, clarifications will be made to data submission specifications, matching to case-mix will allow admission date to be up to 3 days different and if multiple records for a patient the one with the closest matching admit date will be used.
- Staff should have processed data by end of September, and will then analyze data to determine any anomalies, additional exclusions, flag psychiatric cases, and calculate measure by hospital for CY 2023

Next Meeting will be October 8th
9a-11a or 3p-5p
Vote on best time for the group