maryland
health services
cost review commission

ED-Hospital Best Practices Subgroup Meeting

November 1, 2024

Agenda

- Brief update on ED Wait Time Commission meeting 10/23
- Discuss monitoring/model structure and revenue at risk for best practices incentive
- Summary of decisions/discussion during 10/11 Subgroup meeting
- Review hospital responses for final best practices recommendations
- Begin definition of measures, structure of tiers, and evaluate targets

ED Best Practices Incentive Policy Development

Draft Policy December 2024
Final Policy February 2025
*Status update will be provided after Nov Commission meeting

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

ED Wait Time Commission Meeting Update

Commission Priorities:

- Ensure patients are seen in most appropriate setting
- Improve hospital efficiency by maximizing flow of ED and Inpatient (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

Key Action Items:

- Determine necessary subgroups (actively recruiting members)
  - Data subgroup – list of current data requests reviewed and prioritized
  - ED-Hospital “Throughput” Incentives – our existing ED Best Practices Subgroup will constitute this subgroup
  - Access to Post-Acute Care – primary and specialty care, rehab, home health, and SNF access will be evaluated in this group
  - Hospital Capacity, Operations, and Staffing – current access analysis underway to inform this group, will formalize subgroup in Spring 2025

  - The ED WTR Commission will collaborate with the existing behavioral health framework group to address BH opportunities

All commission meeting materials and recording are available on the HSCRC website.

*Meeting minutes have been shared with this group directly

Model structure and revenue at risk

- **Provide a status update on best practice policy at 11/13 HSCRC Commission meeting**
- **Models for discussion**
  - Monitor only for CY25 with accountability measures in place related to implementation of best practices; transition to revenue at risk in CY26 after monitoring period
  - Revenue at risk/ penalty reward model tied directly to best practices tiers with x % revenue at risk; HSCRC Commission proposed 1% initially; as part of recommendation counter propose x%
  - No incentive tied to best practices, but increase incentive tied to ED LOS outcome measure in QBR

    *Note: If no significant improvement in ED LOS occurs in CY25, an increased weight in QBR would be anticipated separate from the best practices consideration.

Summary of 10/11 meeting

Based on discussion from the meeting, we decided that we will recommend picking 3 interventions from a drop-down menu of 6 interventions.

The four interventions selected on 10/11 were:

- Patient flow throughput PI council
- Bed capacity Alert Process
- Interdisciplinary Rounds
- Standard Daily/Shift Huddles

The four interventions suggested for consideration to fill the remaining two slots are:

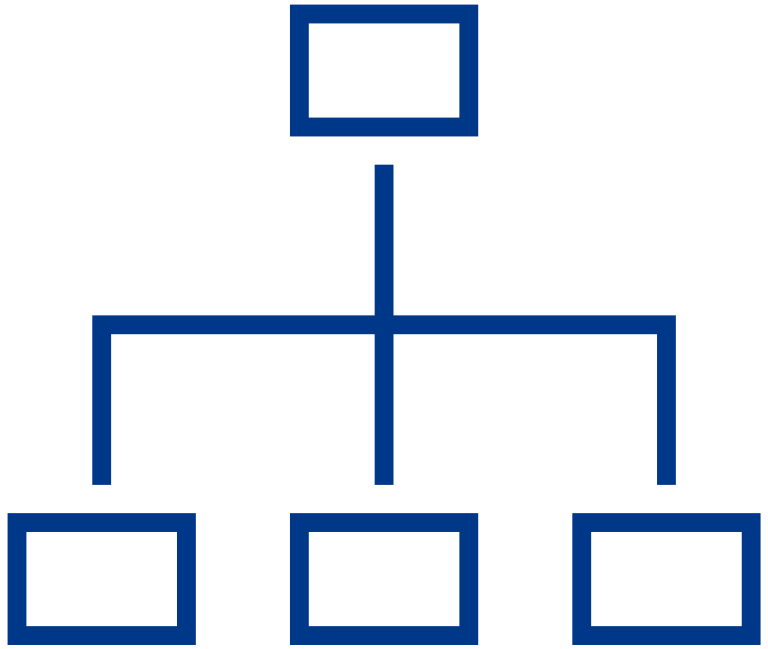
- Establishing clinical pathways/possibly combine this with care transition defined broadly
- Expedited care bucket--inclusive of expediting team, rapid medical eval, rapid eval unit and observation patient management
- Discharge lounge
- Discharge by noon

Recommendation received for remaining best practice options

- 4 recommendations received for establishing clinical pathways/possibly combine this with care transition defined broadly
- 4 recommendations received for expedited care bucket--inclusive of expediting team, rapid medical eval, rapid eval unit and observation patient management
- 2 recommendations received for discharge lounge
- 2 recommendations received for discharge by noon (specific time designated by organization)

Discussion of Tiers

- 3 Tiers, Tier 3 more heavily weighted
  - Example below:
  - Tier 1—1 point
  - Tier 2-up to 4 points
  - Tier 3—up to 10 points
- Specific KPIs with defined targets built into each tier



Example of Tiers for Discussion

- Interdisciplinary Rounds
  - Tier 1—Documentation of Interdisciplinary rounds performed with a target of x%
  - Tier 2—Tier 1 requirement plus Documentation of discharge planning initiated Day 1
  - Tier 3—Tier 1 & 2 requirements and as clinically necessary:
    - PT eval ordered or initiated by x day/ time
    - specialist consult occurs within 24 hours of order
    - SDOH Screening Day 1, target x %
    - Positive SDOH screening has referral triggered within x timeframe
    - Early Prior auth initiated for post-acute placement, target x%
    - Pharmacy IV to PO conversion accepted, target x%

  **these are suggestions for the purpose of discussion

- Specific KPIs with defined targets built into each tier

Next Steps

- Continue development of measure definition, tiers, and targets
- Solicit feedback from HSCRC commissioners
- Next meeting—Friday 11/15 or 11/22, 0900-1100