The impact of the patient population on ED operations:

Patient Complexity and Throughput

James Scheulen & Heather Blonsky
AAAEM Benchmark Committee
Vizient, Inc

Benchmarking in Emergency Medicine
Building a Cohort

“Our patients are sicker…”
“Our patients are different…”
“Our patients need more…”



Introductions

Benchmark Committee: 20 EM Administrators and Physician Leaders

Benchmarking in EM

- **Academic Departments of Emergency Medicine**
  - **Academic Medical Center focus**
    - **Clinical Care, Research, Education**
  - **Community Hospitals as part of Health Systems**

- **Benchmarking ED and Faculty Performance**

Benchmarking in EM

Comparing the activity or operations of one emergency department with others for the purpose of quality or process improvement

DEMOGRAPHICS														
Region	Institution Type	Peds ED Separate	Staff Peds ED	Provider in Triage	Provider Triage Hours/ Day	Fast Track?	Boarding Pts: Who Provides Care	Boarding ICU Pts: Who Provides Care	Boarding Pts: Hosp provides Nursing support	Boarding Pts: Hosp provides financial support?	Trauma Center Level	Charting Assistance Used		Licensed Hospital Beds
Midwest					0		**Inpatient**	**Inpatient**			**I**	**Scribes**		105
18	**Private**	**Yes**	**Yes**	**Yes**	0	**Yes**	58	39	**Yes**	**Yes**	62	5		479
Northeast	49	44%	40%	54%	9	78%	**ED**	**ED**	41%	24%	**II**	**Dictation**		655
37					16		24	37			5	51		826
South	**State**	**No**	**No**	**No**	32	**No**	**ED Hospitalists**	**ED Hospitalists**	**No**	**No**	**III**	**Both**		1,541
20	39	56%	60%	46%	9	22%	1	0	59%	76%	1	24		668
West					9									655
18	**88**	**90**	**87**	**90**	**58**	**88**	**83**	**80**	**82**	**79**	**85**	**88**		**85**
Northeast	Private	Yes	Yes	Attending only	17	Yes	Inpatient	ED providers	Yes	No	I	Both		656
Northeast	Private	No	No	Attending only	13	No	Inpatient	ED providers	No	No	Not Applicable	Both		247
Midwest	Private	Yes	No	No	0	Yes	ED	ED providers	Yes	No	I	Neither		1,034

AAAEM/AACEM Benchmarks

- **Benchmark Presentations**
  - **Emergency Department Operations**
  - **Emergency Medicine Research and Education**
  - **Faculty and APP Staffing**
  - **Faculty and APP Demographics and Salary**
  - **Special Section/Research Reports**
    - **Development of Operations Based Complexity Index**
    - **Development of Patient Based Complexity Score**

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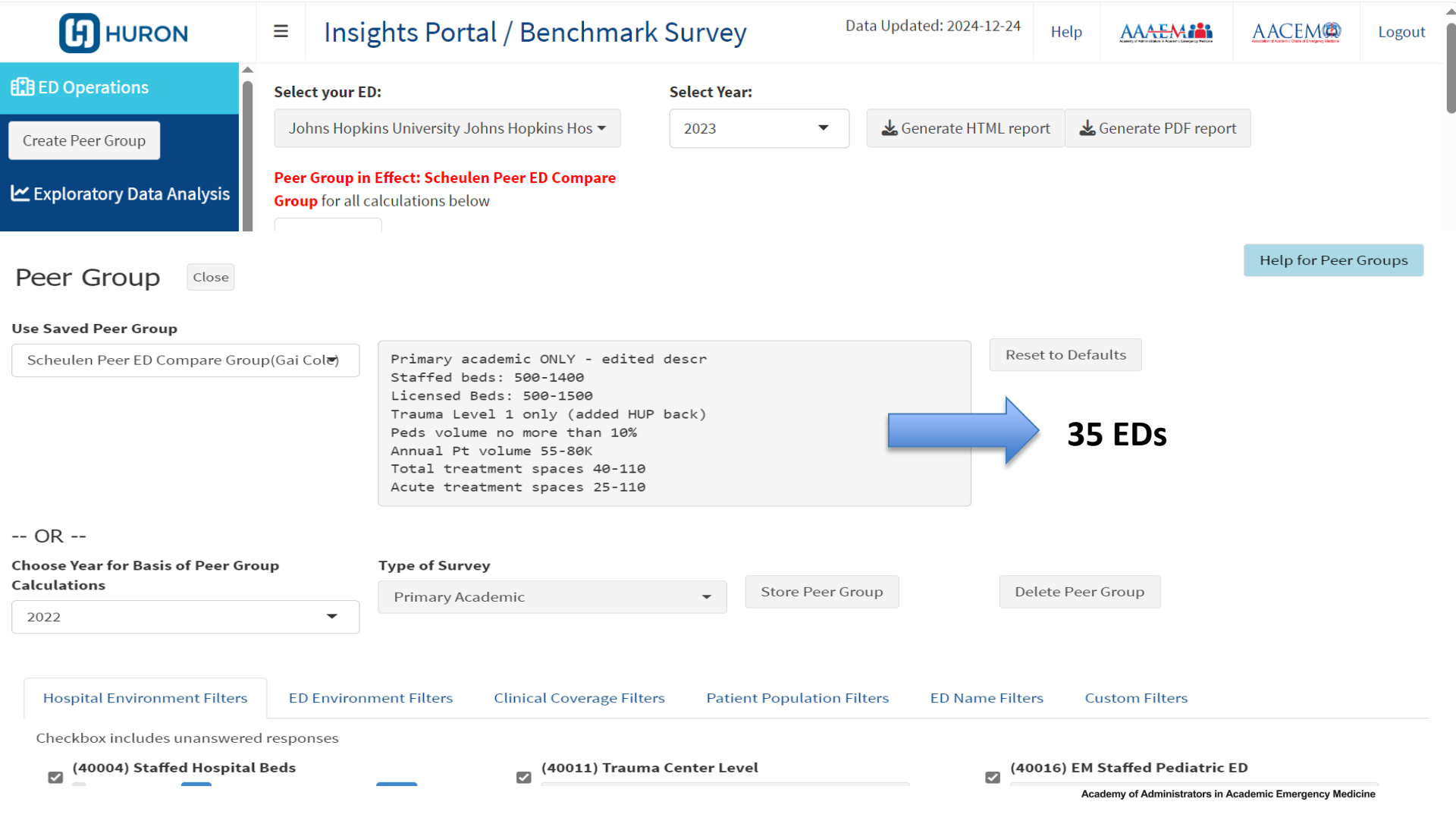
Benchmarking in EM



The Academic ED

Fiscal Year 2023	Median
Hospital Beds	604
Licensed ED Beds	57
Total Bed Hours	*536,560*
% Bed Hours to MAIN	*69%*
ED Treat & D/C	38,248
ED Admissions	14,803
Hospital Observation	2,854
Total Visits	63,591
Hospitalized Rate (Calc)	27.8%
Unique visits	66.4%

63,591 Visits

Range: 28,011 – 144,710

40,878 Unique visits

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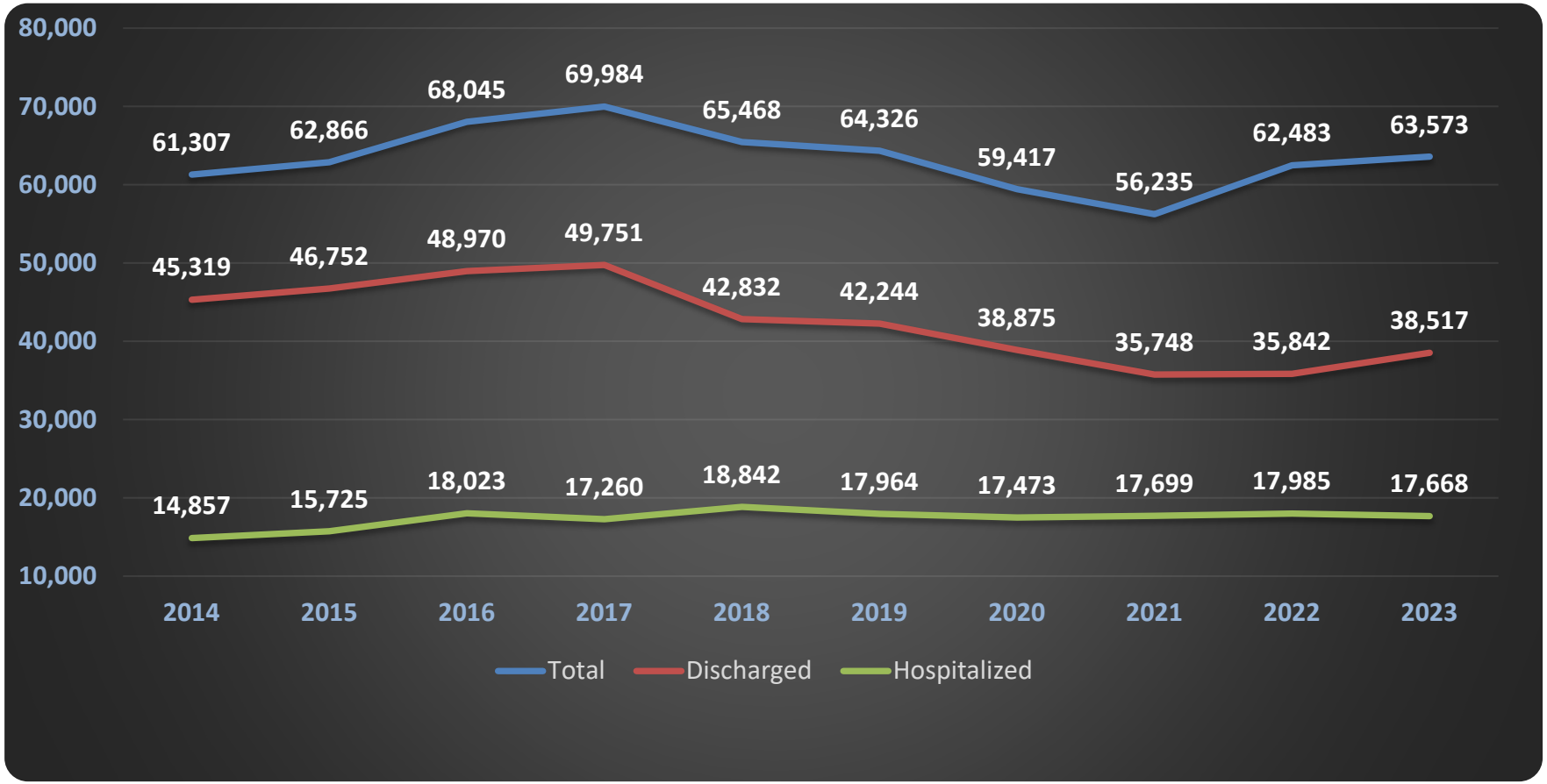
Patient Volume Trend: Median

Patient Volume Trend—All Responders FY 23



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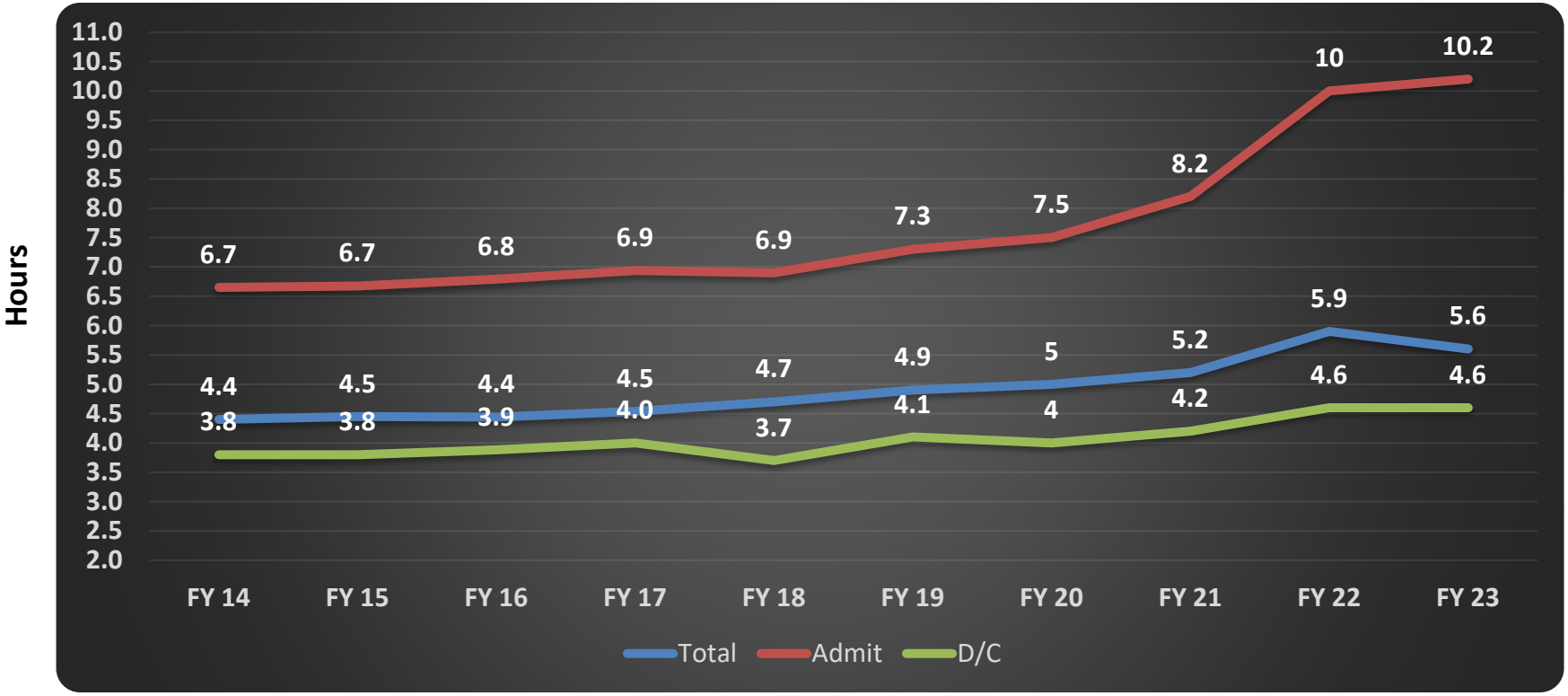
LOS Trend: Median LOS

Median Emergency Department Length of Stay



Median times represented here
Mean times are longer
Distribution with a long right tail

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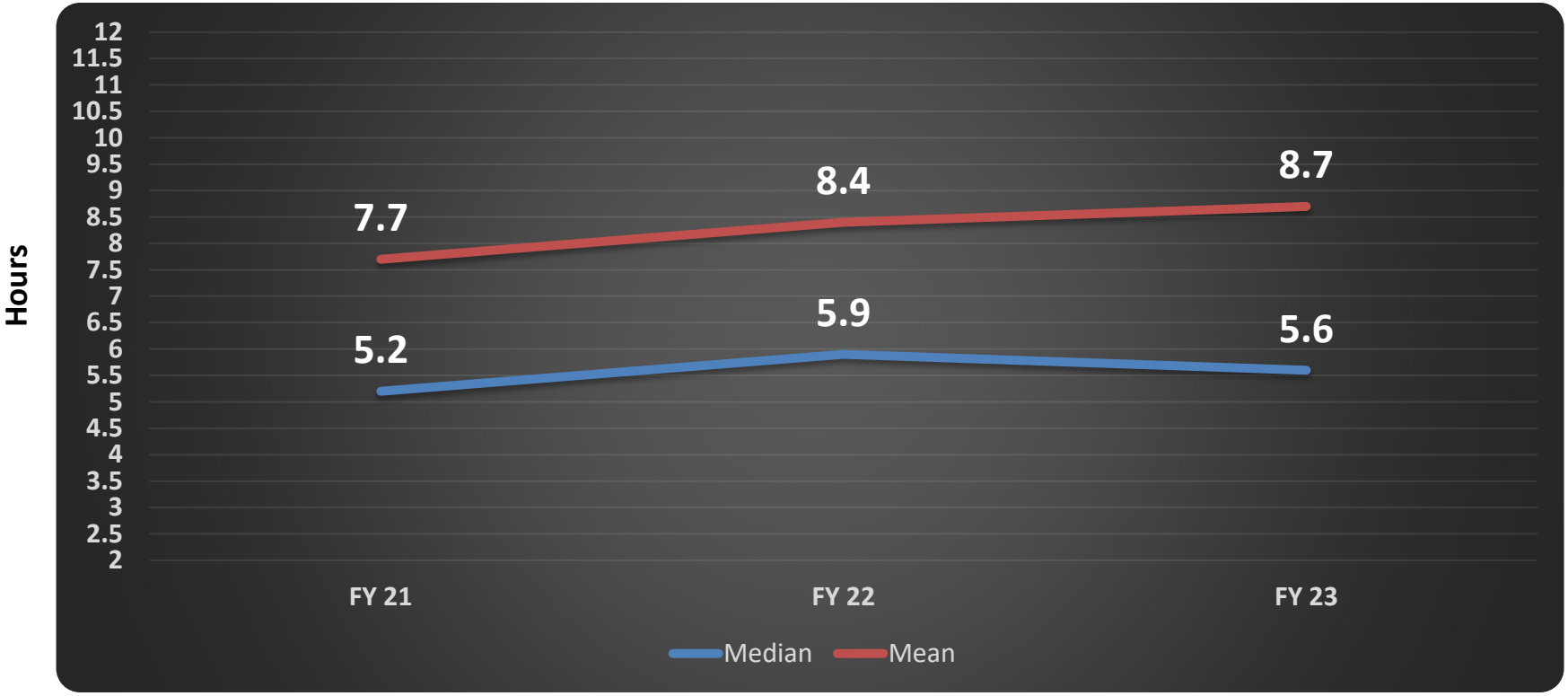
LOS Trend: Median vs Mean LOS

Total ED LOS: Mean vs Median



Mean times represent what staff and patients experience

Data distribution has a long right tail

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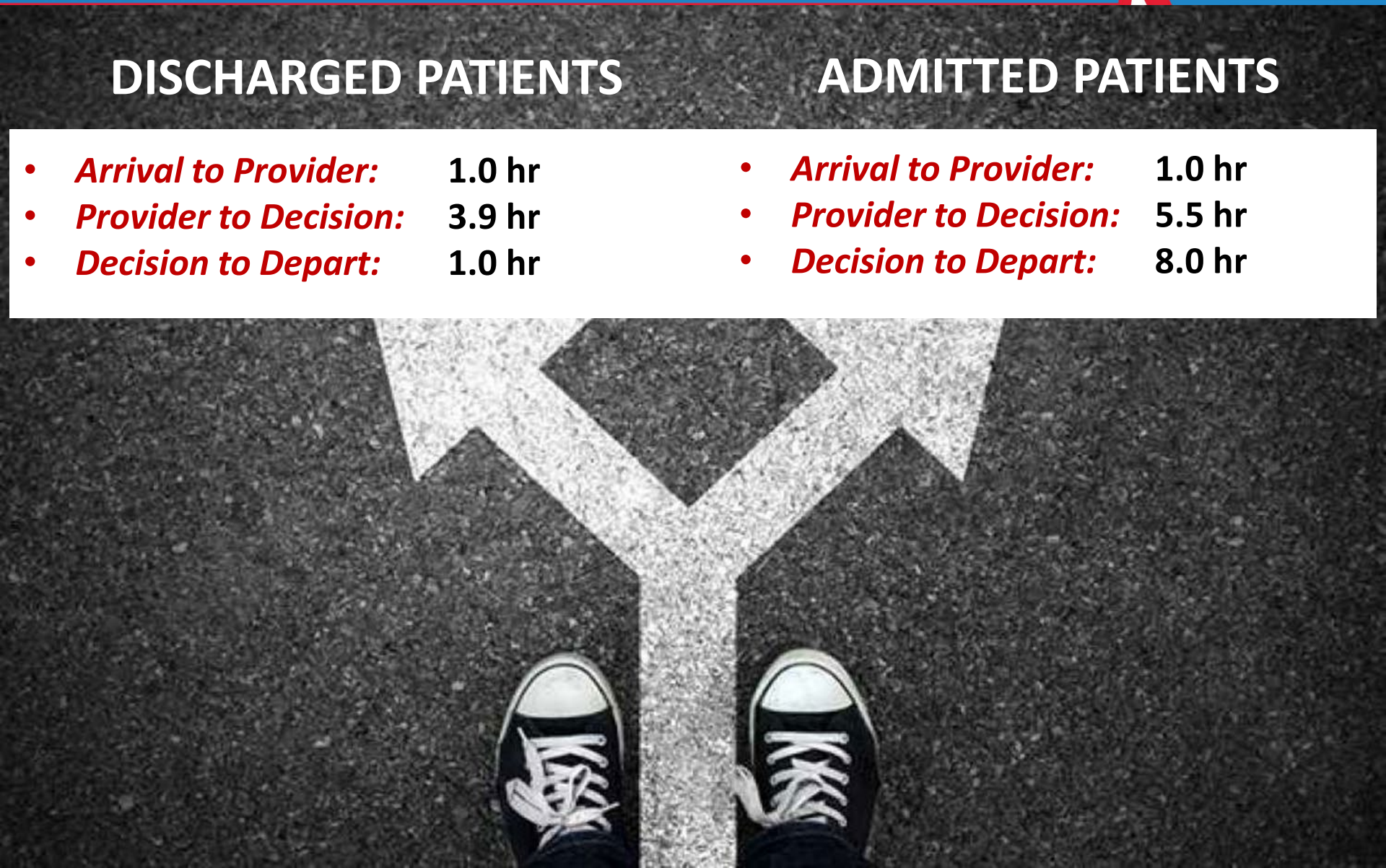
Sub-cycle Time



DISCHARGED PATIENTS

- ***Arrival to Provider:*** **1.0 hr**
- ***Provider to Decision:*** **3.9 hr**
- ***Decision to Depart:*** **1.0 hr**

ADMITTED PATIENTS

- ***Arrival to Provider:*** **1.0 hr**
- ***Provider to Decision:*** **5.5 hr**
- ***Decision to Depart:*** **8.0 hr**

Ancillary Resource Utilization

Resource	FY 19	FY 20	FY 21	FY 22	FY 23
CT Utilization	25.5%	Mean = 2.3 hours vs 2.8 hours			31.5%
MRI Utilization	2.7%	2.8%	2.8%	2.9%	3.2%

Mean CT Process time has increased by 39%

Mean MR process time has increased by 169%

CT and MR Utilization account for 65,000 hours of process time

If patients are in beds, we now dedicate *AN ADDITIONAL 2 beds* entirely to CT/MR wait: *7 beds* entirely dedicated to process wait time

MRI Turnaround	4.0 hr	Mean = 5.0 hours vs 11.3 hrs			5.5 hr

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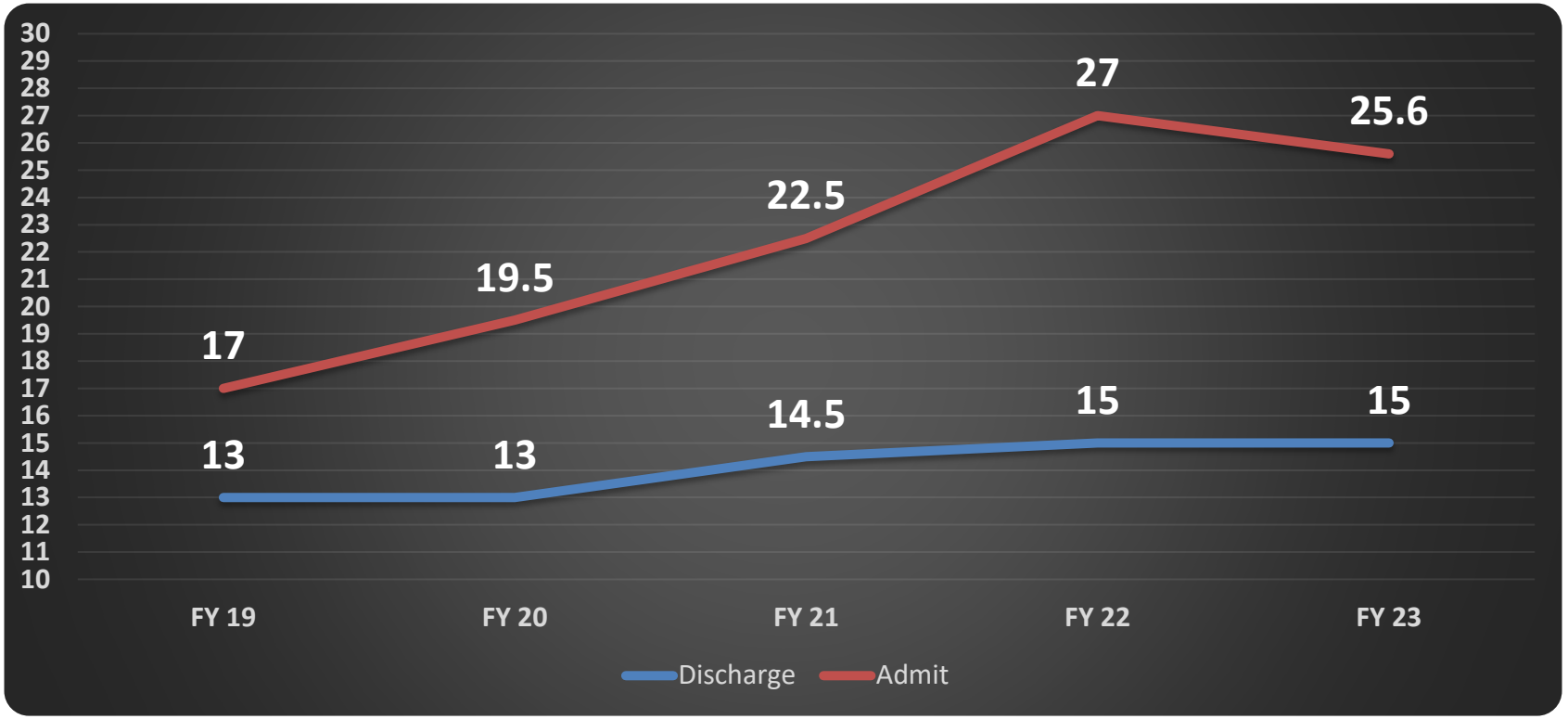
LOS Behavioral Health

Behavioral Health Patients = 5.7% of Arrivals or 3500 patients



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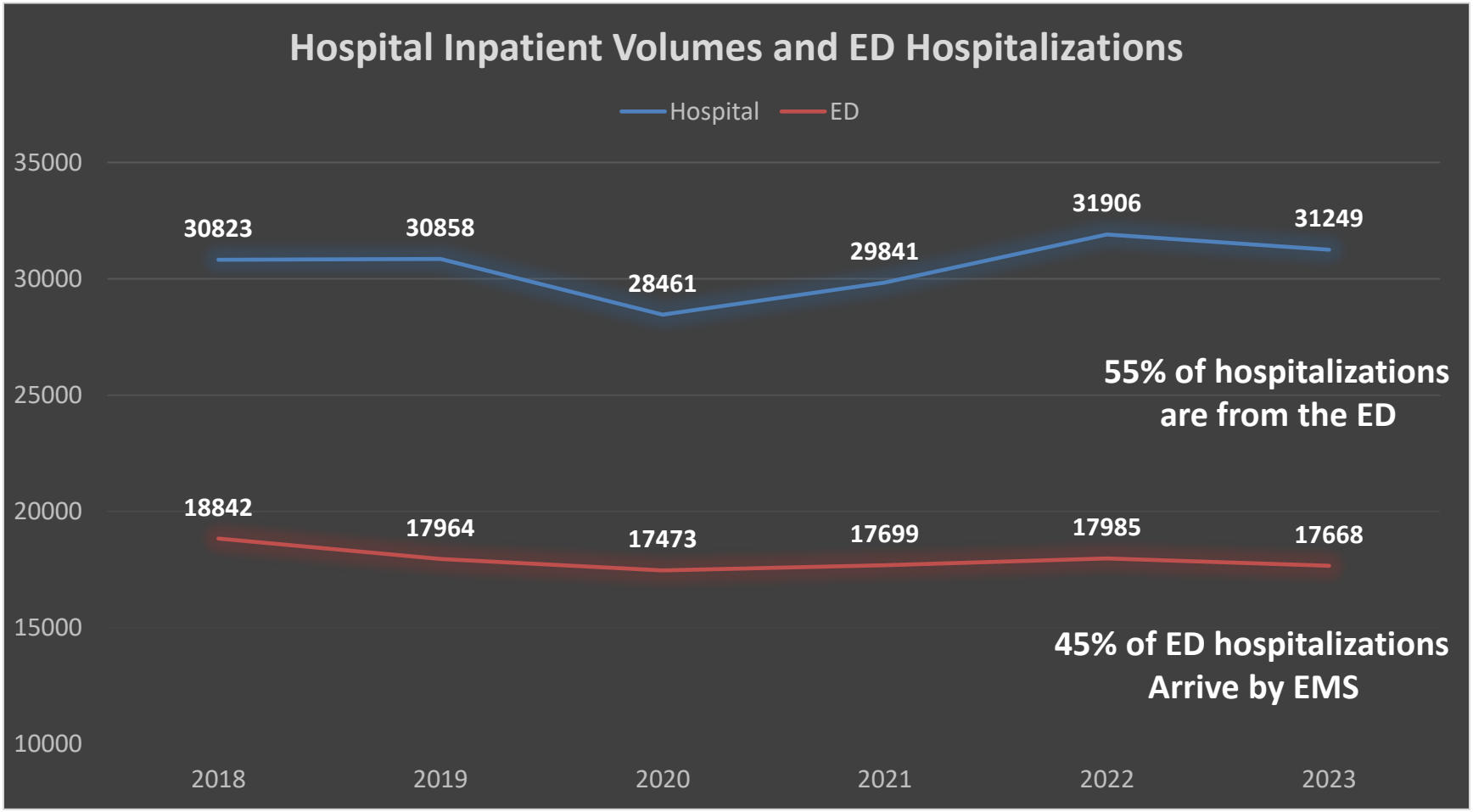
Hospitalization Data



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Inpatient Occupancy

All beds

Academic = 89%

DOM beds

Academic = 91%

DOM beds

Academic = 94%

Approximately 80% of all patients in DOM come from the ED
Approximately 67% of all ED hospitalizations go to DOM

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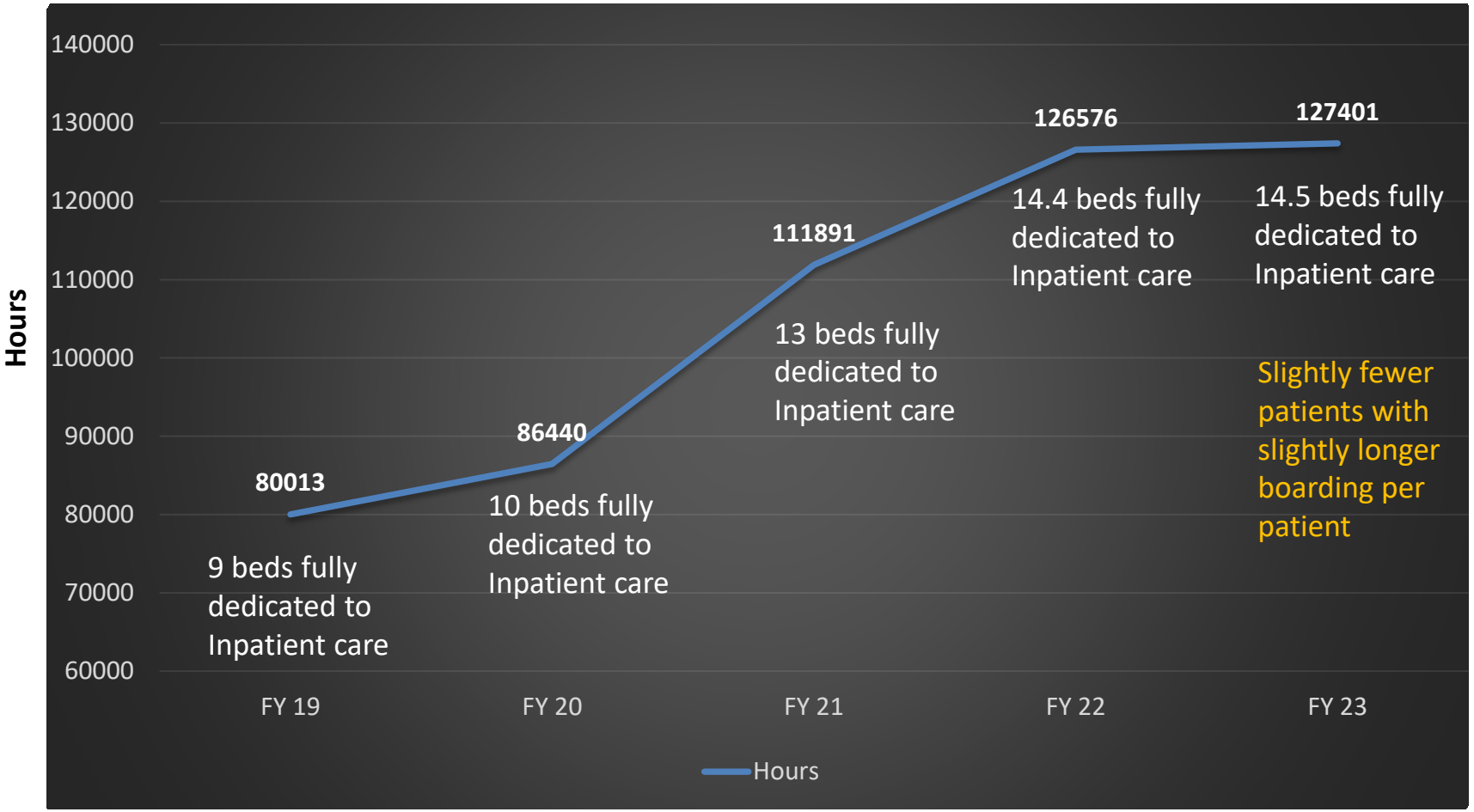
Boarding Time

Total Boarding Hours



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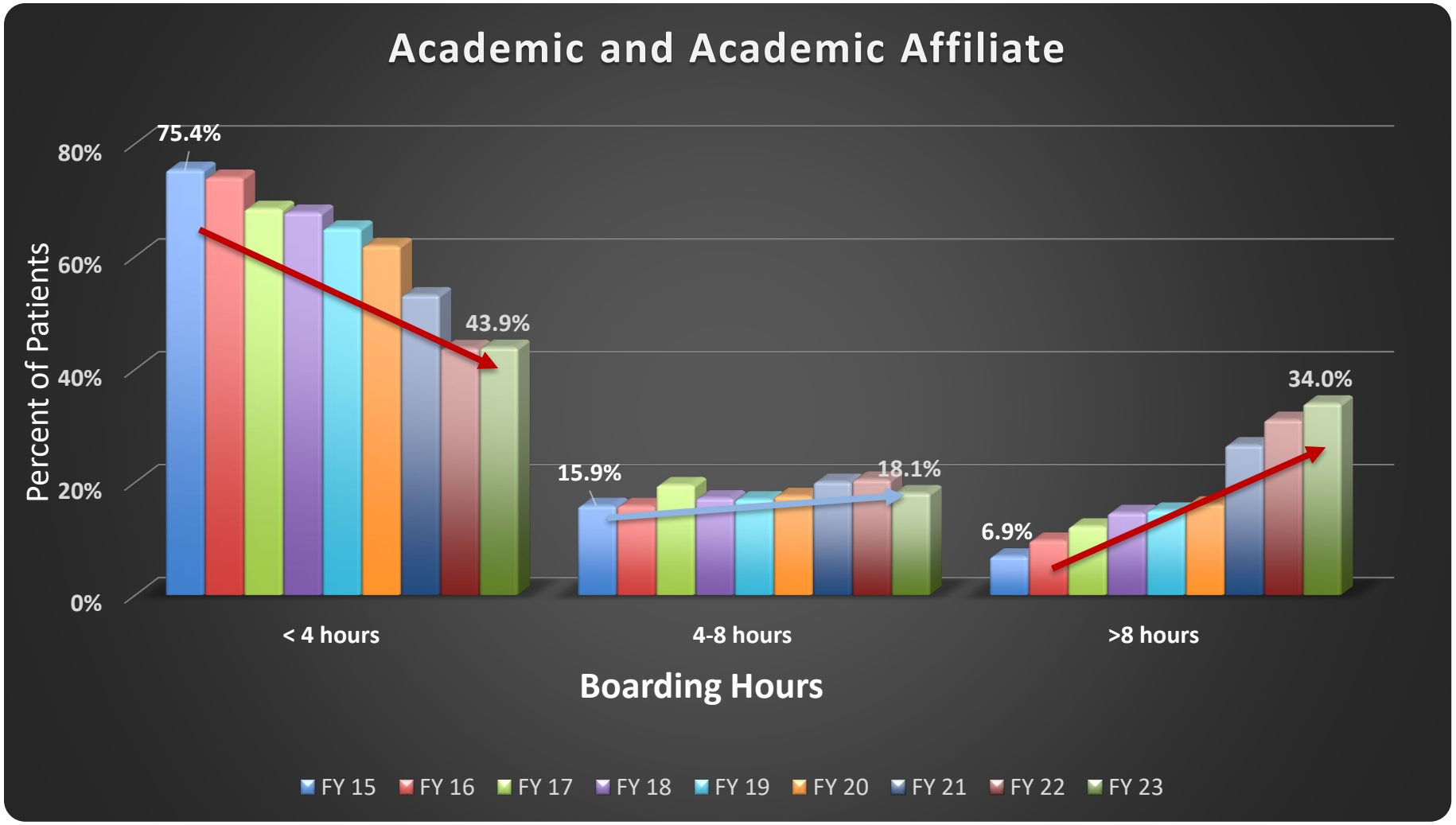
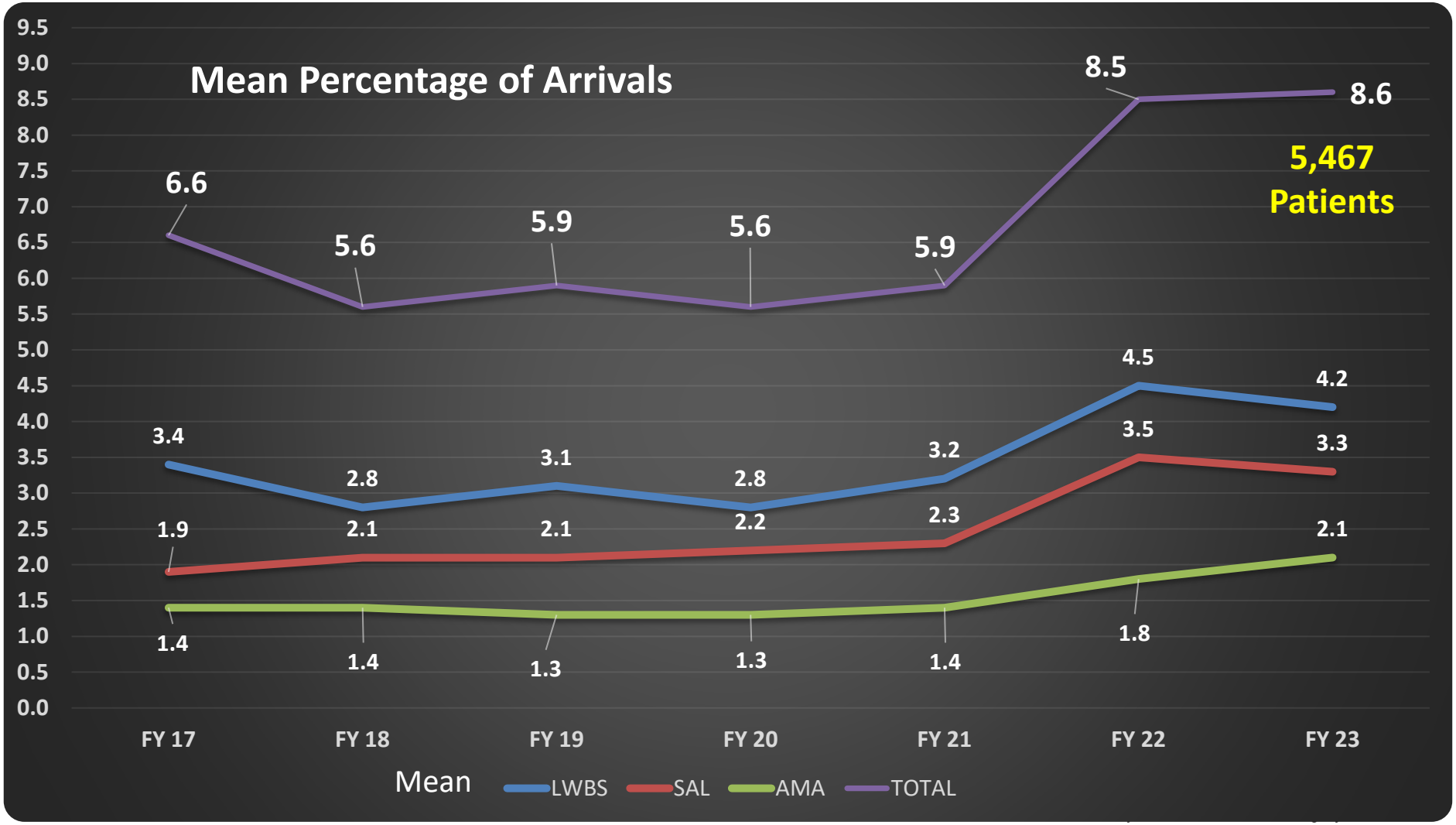
Boarding Distribution

FY 2015 vs FY 2023



Left Before Treatment Complete



Benchmarking in EM

Comparing the activity or operations of one emergency department with others for the purpose of quality or process improvement

Operational data

"Defines" the department

Develop a cohort to compare

Data is not patient level data

Region									Boarding	Boarding			Licensed Hospital Beds
Midwest					0		Inpatient	Inpatient			I	Scribes	105
18	Private	Yes	Yes	Yes	0	Yes	58	39	Yes	Yes	62	5	479
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Defining your department

Developing the right cohort
Understanding resource needs

Operational Variables

- Visit volume
- Teaching vs Community
- Hospitalization rate
- EMS arrivals

Patient Population

- Patient history
- Presenting complaint
- Co-morbidities
- Social needs

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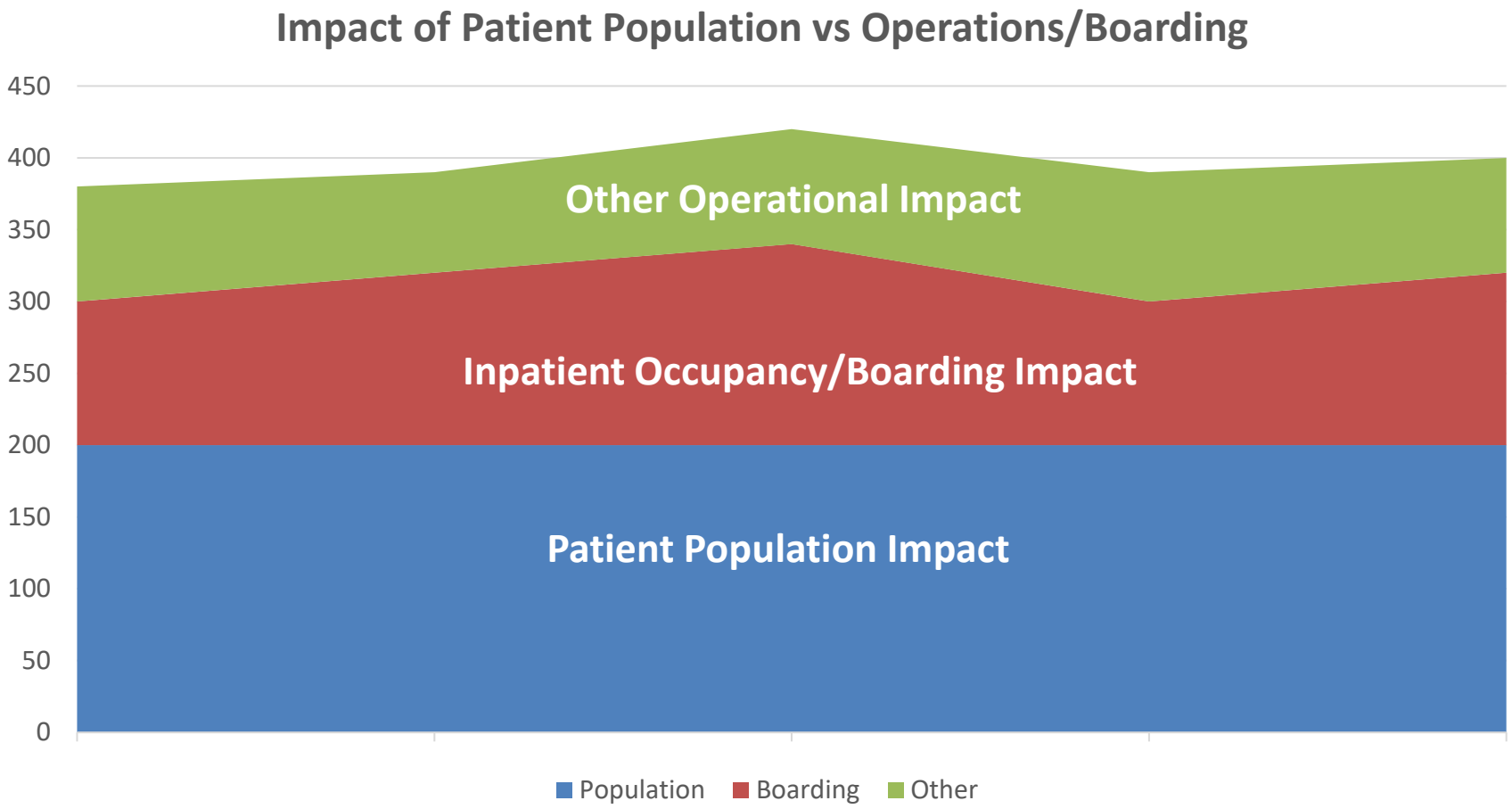
Throughput Impact Layers



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Benchmarking in EM

How does the composition or complexity of the patient population impact operations

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Patient Population Definition

Understanding the ***composition and complexity of the patient population*** in each emergency department as a way to better understand the ***resources required*** to care for that patient population.

- ***Time*** as a proxy for resource demands
- Patient level data
- ***On any given day, what do we face?***
  - Interactions between patient variables

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Social Needs

Multiple Chronic Conditions and Age

Mental Health Issues

Specific Complaints or Diagnoses

Patient Population

Our Challenge

- **A way to describe a patient population**
- **A way to consider multiple patient based variables**
- **A way to compare among ourselves**
- **A way to compare ourselves to ourselves over time**

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Acuity versus Complexity

Acuity

Severity of illness

Priority setting

Implies ***SPEED*** is required

Complexity

Multiple care needs

Personal, social and clinical needs together

Implies ***TIME*** is required

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Previous Efforts

OPERATIONAL METRICS

CASE MIX INDEX FOR ED ADMISSIONS

COMPLEXITY INDEX DEVELOPMENT

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Inpatient Case-Mix Index

- **Inpatient Case Mix Index: Hospitalized from ED**
  - Resource based index
  - Indicates acuity/complexity but impacted by high cost treatments

	CMI w/o HAC
Primary Academic	1.94
ED Admissions	1.80
Non-ED	2.07
Community	1.45
ED Admissions	1.45
Non-ED	1.49

AMC > Community Hospital

AMC ED > Community ED

Non-ED > ED Hospitalizations

Community ED = Non-ED

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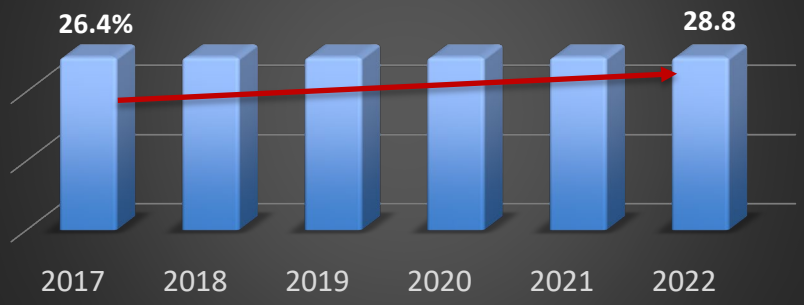
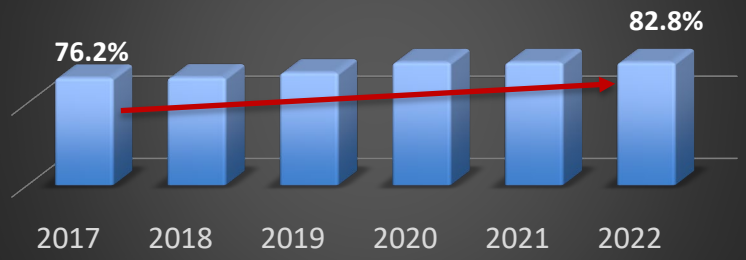
Complexity Metrics: As a group

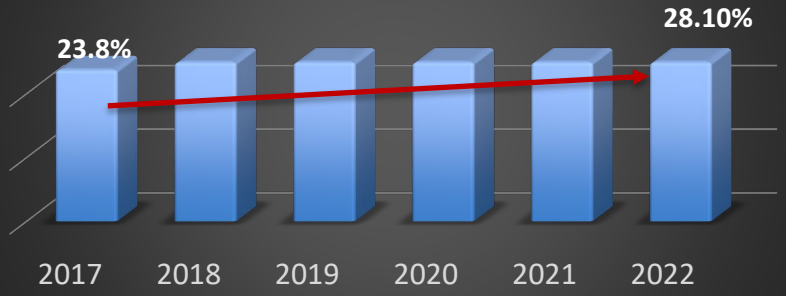
Hospitalization Rate



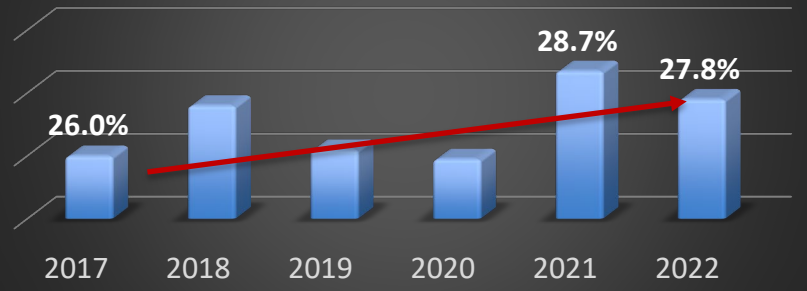
High Acuity Profee Codes



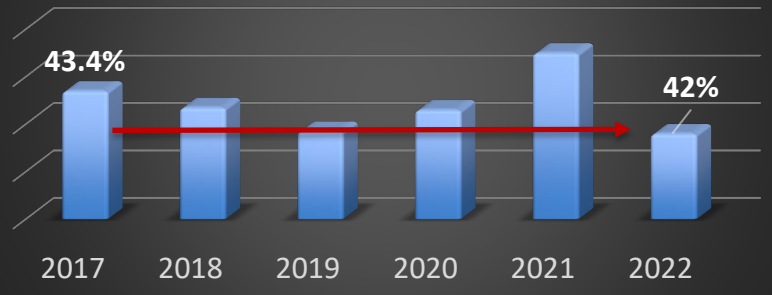
Acuity 1/2



EMS Arrivals



EMS Admissions



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Operations Based Complexity Index

Complexity Index: Data Preprocessing and Methodological Comparison

AAAEM/AACEM Benchmark Committee and Roundtable Analytics, Inc.

February 28, 2020

Produce an Index Score and Rank for each Academic Center

- **Number of Arrivals**
- **Ratio of % ESI-1/2 to % ESI-4/5**
- **% ED Arrivals Hospitalized**
- **% Arrivals by EMS**
- **% EMS Arrivals Hospitalized**
- **% Profee 4/5/CC**

4 Versions of Complexity Index
Principal Component Analysis
Blended Versions

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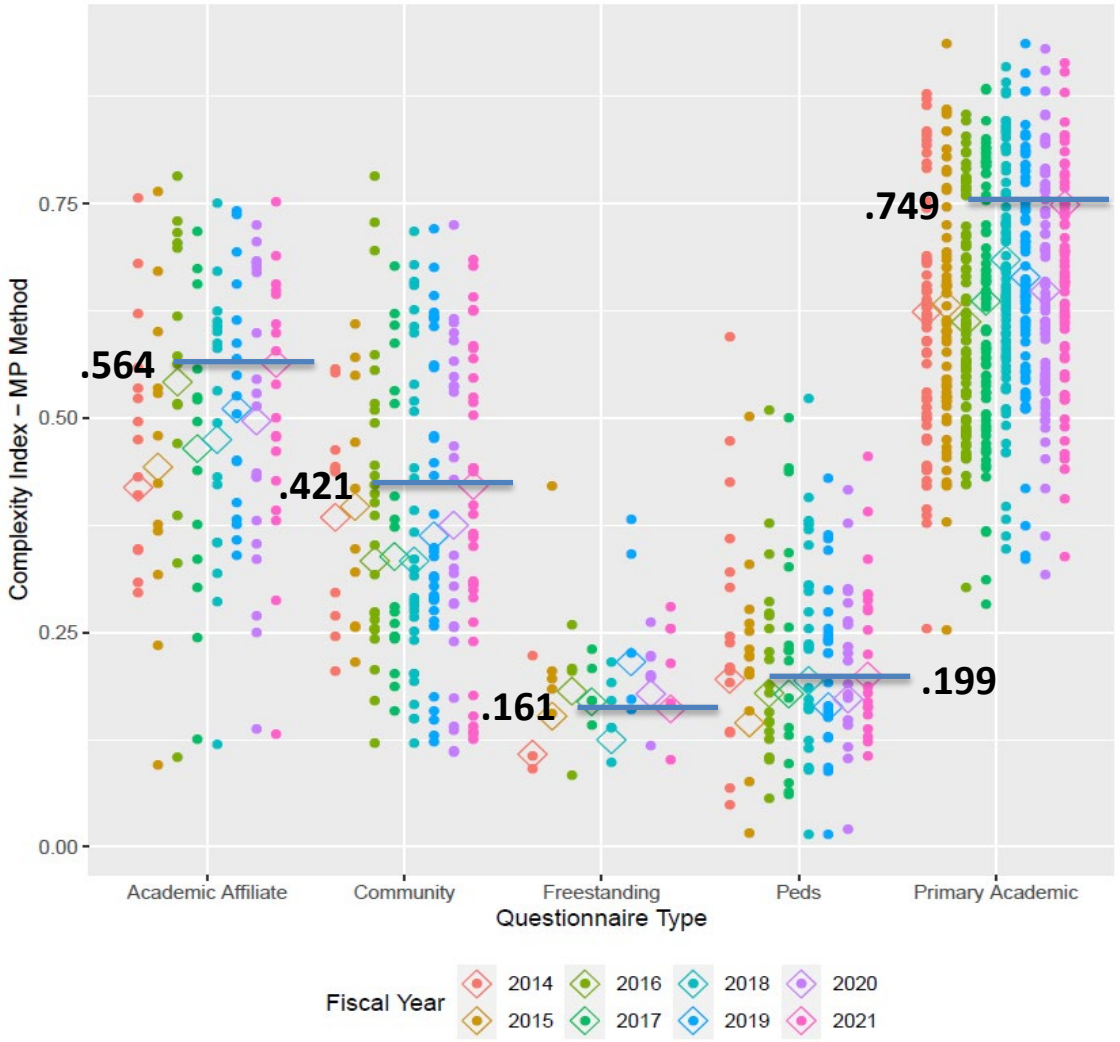
Operations Based Complexity Index

Fiscal Year 2021

- **Hospitalization rate**
- **EMS Arrivals**
- **EMS Admissions**
- **High Acuity Codes**
- **Acuity 1&2 vs 3&4**



Operations Based Complexity Index

Complexity Index Ranking

University	ED Type	Complexity Index	Overall Ran	ED Type R
University of Massachusetts / Baystate	Primary Academic	0.942708333	1	1
University of Florida, Gainesville	Primary Academic	0.902083333	2	2
The Ohio State University	Primary Academic	0.890625	3	3
Harvard University / Beth Israel Deaconess	Primary Academic	0.88125	4	4
Medical College of Wisconsin	Primary Academic	0.877083333	5	5
University of Kansas School of Medicine	Primary Academic	0.864583333	6	6
Vanderbilt University	Primary Academic	0.855208333	7	7
Virginia Tech University	Primary Academic	0.845833333	8	8
Harvard Medical School	Primary Academic	0.840625	9	9
University of Texas Health Sciences - Houston	Primary Academic	0.817708333	10	10
Washington University @ St. Louis	Primary Academic	0.796875	11	11
University of Texas, Southwestern	Academic Affiliate	0.788541667	12	1
Yale University	Primary Academic	0.7875	13	12
Loma Linda University	Primary Academic	0.780208333	14	13
Penn State University	Primary Academic	0.778125	15	14
University of Michigan	Primary Academic	0.777083333	16	15
University of Rochester	Primary Academic	0.777083333	17	16
Texas A&M University	Primary Academic	0.776041667	18	17
Duke University	Primary Academic	0.772916667	19	18

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52
111/70
87
27

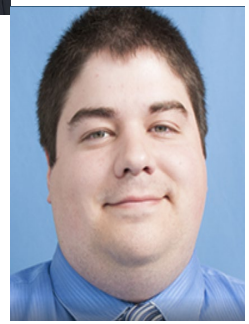
Patient Based Complexity

- **Collaboration with Vizient**
  - Membership PI Organization
  - **Most AMCs (*95% of our members*)**
  - Clinical Data Base from members
- **Patient Based Complexity Measure**
  - Patient level data
  - ***Encounter specific metrics: Hospital Coding***
    - Demographics (Age)
    - Presentations
    - Diagnoses
    - Co-morbidities
    - Social needs
  - ***Impact on Throughput***

vizient®

Heather Blonsky

Jaie Lavoie



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Patient Based Complexity

Quantify differences in the complexity of cases or definition of the patient population seen in different EDs or one ED over time

- Provide context to understanding variables impacting throughput
  - ***Patient Clinical Data***
  - ***Social Needs***
  - ***Variability (Operations)***

Hypothesis:

An emergency department that sees patients with more clinical needs and patients with more social needs will have longer throughput times.

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Patient Based Complexity Model

Creating the Model

Initial Data Set: 4 Hospitals
Vizient Clinical Data Base
280 patient level variables

Small sample size for model

Provided throughput data points
2 years of daily patient level data

Principal Component Analysis
Streamlined variables

On this day in the ED

- **Age and co-morbidities**
- **Current diagnoses**
  - **Psychosis**
  - **Alcohol and/or drugs/depression**
  - **Trauma**
- **Complex history**
- **PCP desert and 7 day returns**
- **Patients from neighborhoods with high social needs (transportation domain)**

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Patient Based Complexity Model

- **Expanded the number and type of hospitals**
  - **10 Health Systems**
    - JHHS, UC Health, Northwestern, Mass General Brigham, UMass, Michigan, Cincinnati, OSU, Jefferson, U Virginia
  - **27 Hospitals**
    - 11 Academic Medical Centers
    - 7 Large Community Hospitals (Affiliates)
    - 7 Small Community Hospitals
    - 2 Critical Access Hospitals

52 Hospitals

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Summary Patient Based Model

Population most impacting operations:

- More patients
- Higher proportion of patients with chronic effects of ETOH
- Higher proportion of patients with mental health issues (Psychosis)
- Higher proportion of elderly and/or complex patients
  - More than 4 Elixhauser comorbidities
- Higher proportion of patients with oncology Dx
- Higher proportion of patients from neighborhoods with high social needs
  - Transportation challenges
  - Access to health care/PCP desert

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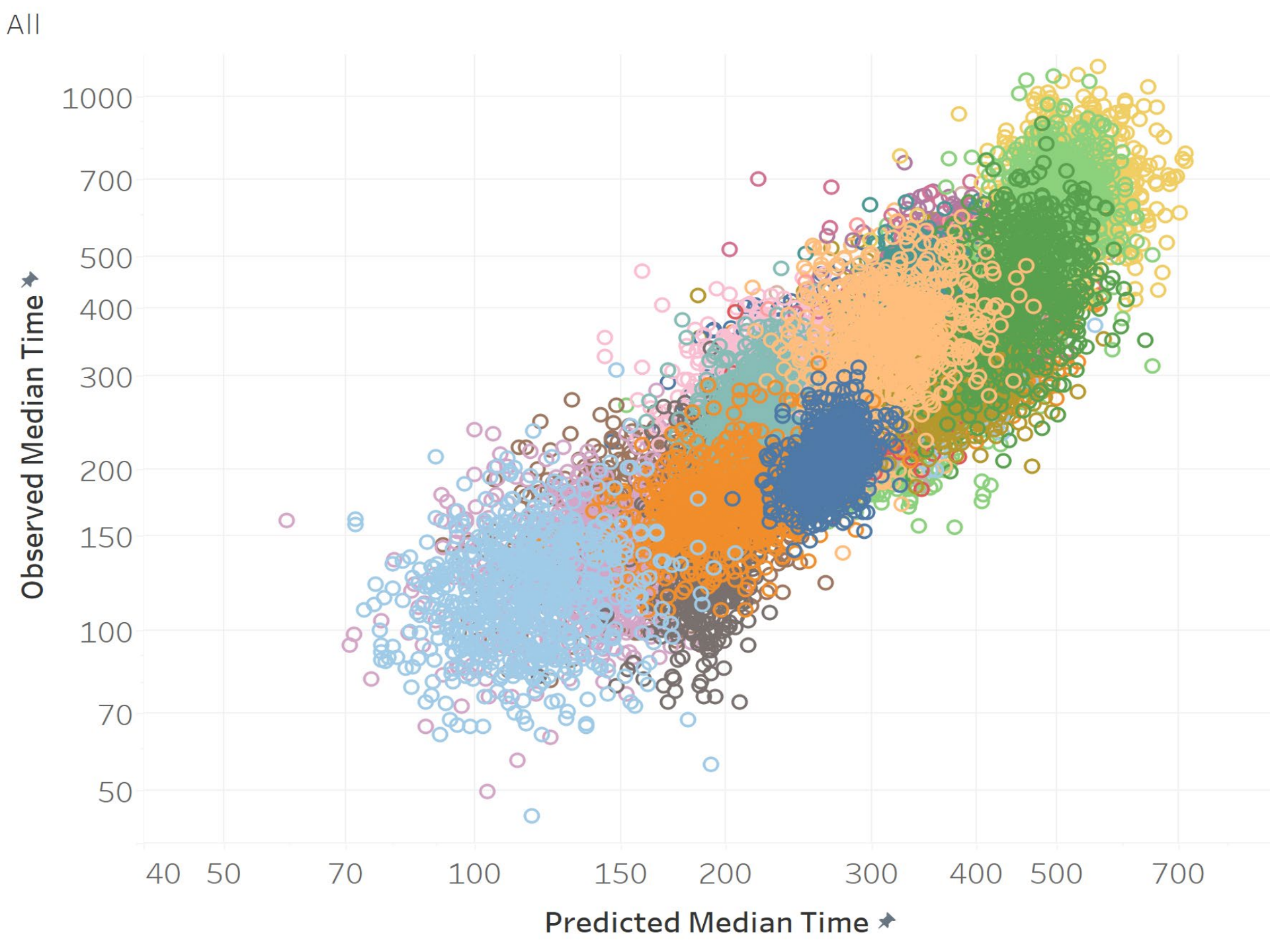
Patient Based Complexity Model

Variables provide a good fit ($r^2 = 0.71$)

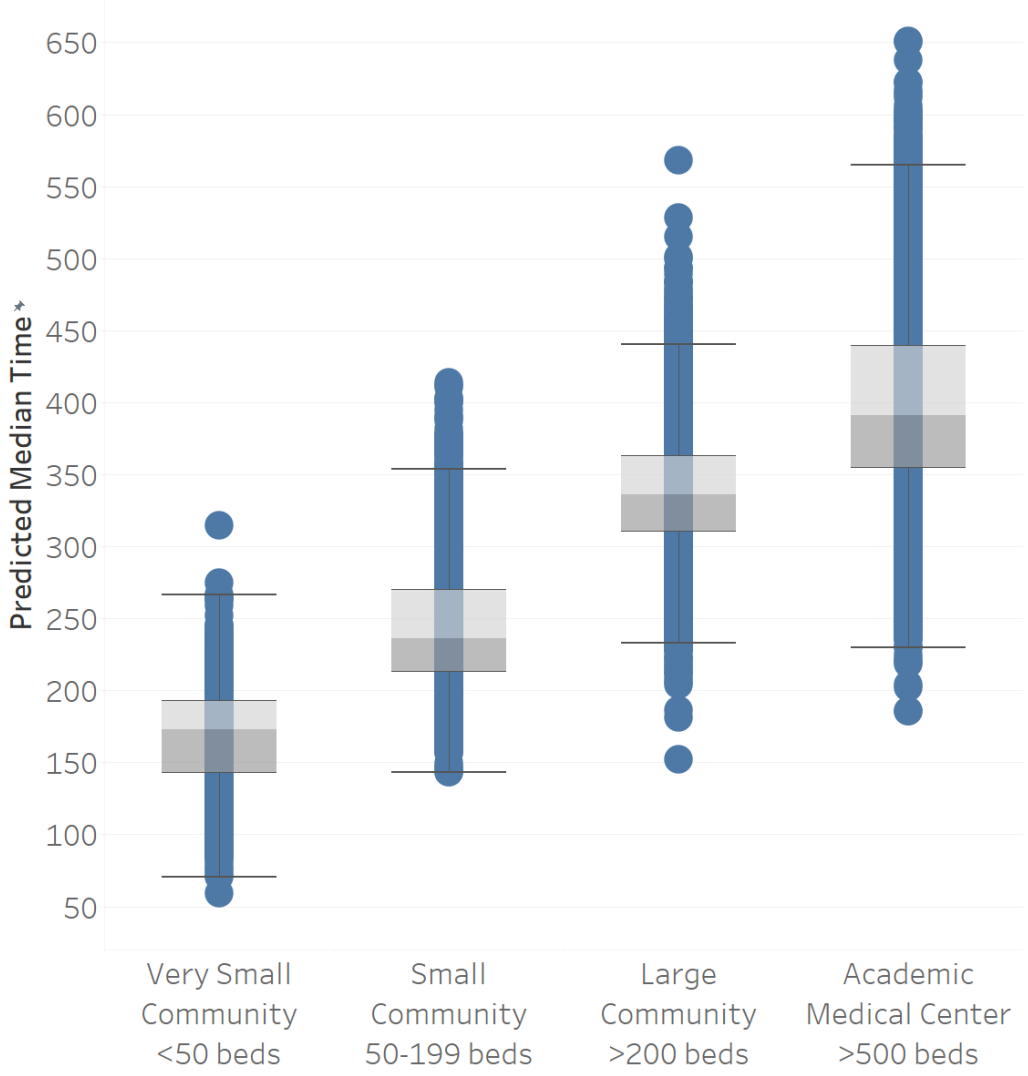
- More patients
- More patients with chronic ETOH
- More patients with psychosis
- More elderly and/or with comorbidities
- More patients with oncology Dx
- Patients from neighborhoods with high social needs/PCP desert
- Reduced time = more patients with:
  - Current drug or alcohol overdose
  - History of 7-day returns to the ED
  - Severe trauma

Parameter Estimates

Variable	DF	Parameter Estimate	Standard Error	t Value	Pr > |t|	Variance Inflation
Intercept	1	1.72420	0.00844	204.39	<.0001	0
logcountEncounters	1	0.26441	0.00332	79.66	<.0001	1.80271
elderlycomplex_pct	1	0.54292	0.03768	14.41	<.0001	3.61055
elderlyorcomplex_pct	1	0.13184	0.01351	9.76	<.0001	1.98338
depression_pct	1	0.30474	0.02607	11.69	<.0001	2.98850
psychosis_pct	1	0.73521	0.05640	13.04	<.0001	2.17136
drugs_pct	1	-0.65709	0.01535	-42.81	<.0001	2.01709
alcohol_chronic_pct	1	1.38677	0.09917	13.98	<.0001	1.08316
hf_pct	1	0.42824	0.04181	10.24	<.0001	2.38631
ami_pct	1	1.39015	0.12972	10.72	<.0001	1.05410
oncology_pct	1	0.53311	0.02819	18.91	<.0001	2.10574
stroke_pct	1	0.49120	0.09667	5.08	<.0001	1.38436
covid_pct	1	0.17618	0.01594	11.06	<.0001	1.02545
trauma_pct	1	0.56129	0.02515	22.31	<.0001	2.20454
trauma_severe_pct	1	-0.77730	0.02538	-30.62	<.0001	2.58417
vvi_pct	1	0.23934	0.00489	48.99	<.0001	2.41054
transportation_pct	1	0.14704	0.00366	40.22	<.0001	1.62815
access_pct	1	1.39098	0.08132	17.10	<.0001	1.11890
pcp_pct	1	0.06822	0.00504	13.54	<.0001	1.58394
ed7day_pct	1	-0.15454	0.01771	-8.72	<.0001	1.61210


All
1000
700
500
400
300
200
150
100
70
50
Observed Median Time
40
50
70
100
150
200
300
400
500
700
Predicted Median Time

Patient Based Complexity Model



Higher complexity for AMCs than for any other cohort

Highest complexity within any one cohort tends to include higher numbers of patients with increased social needs

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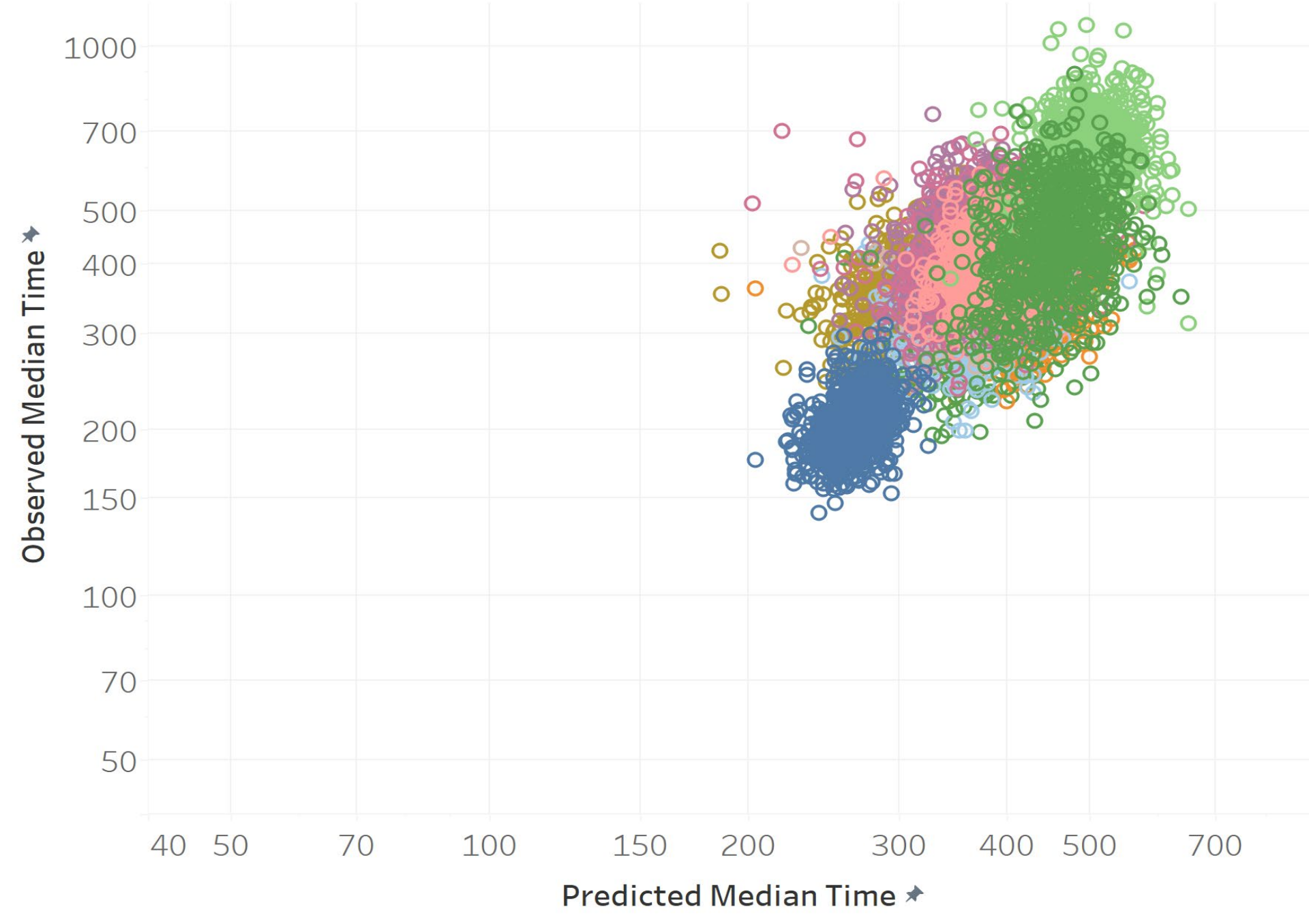
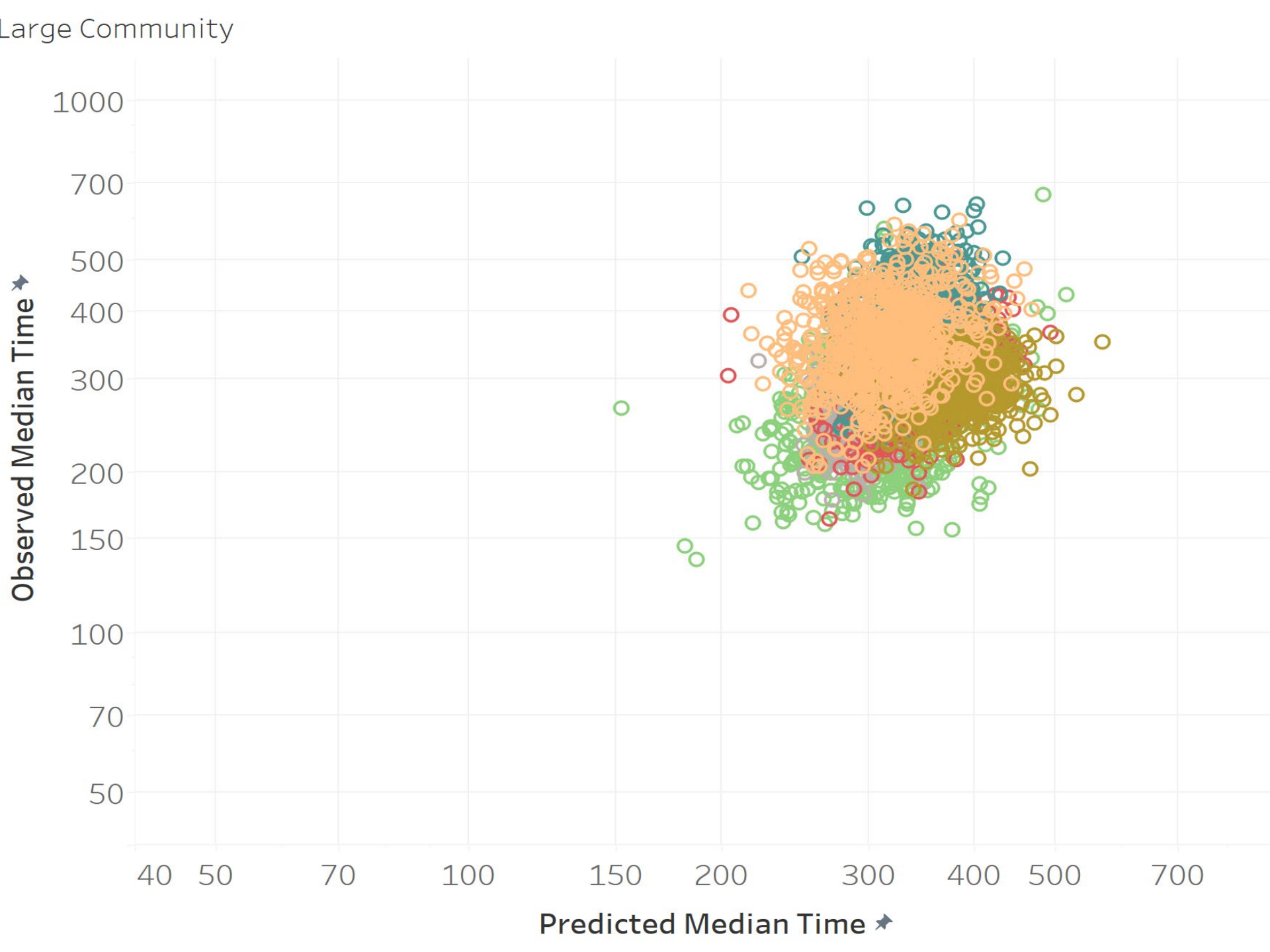
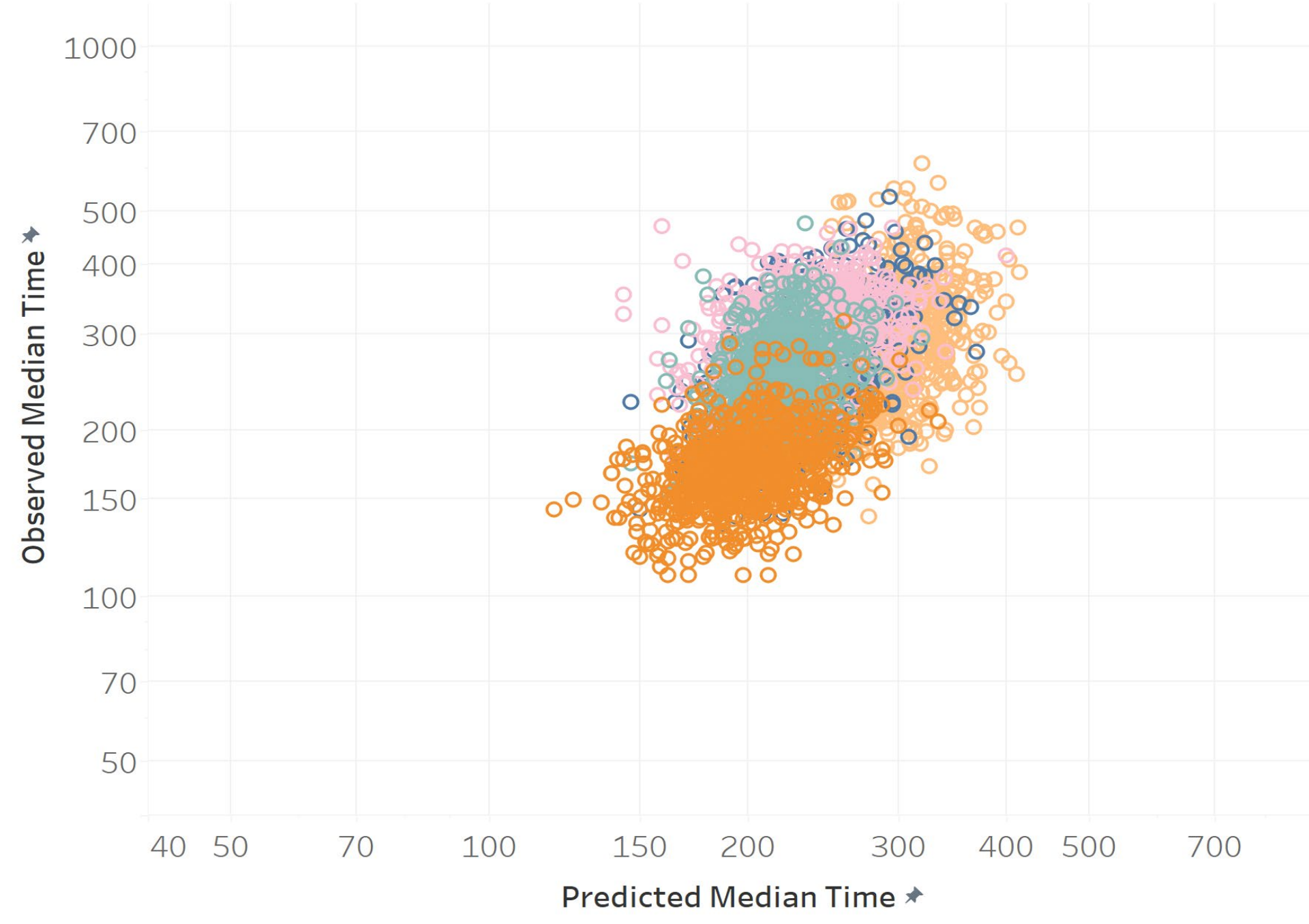
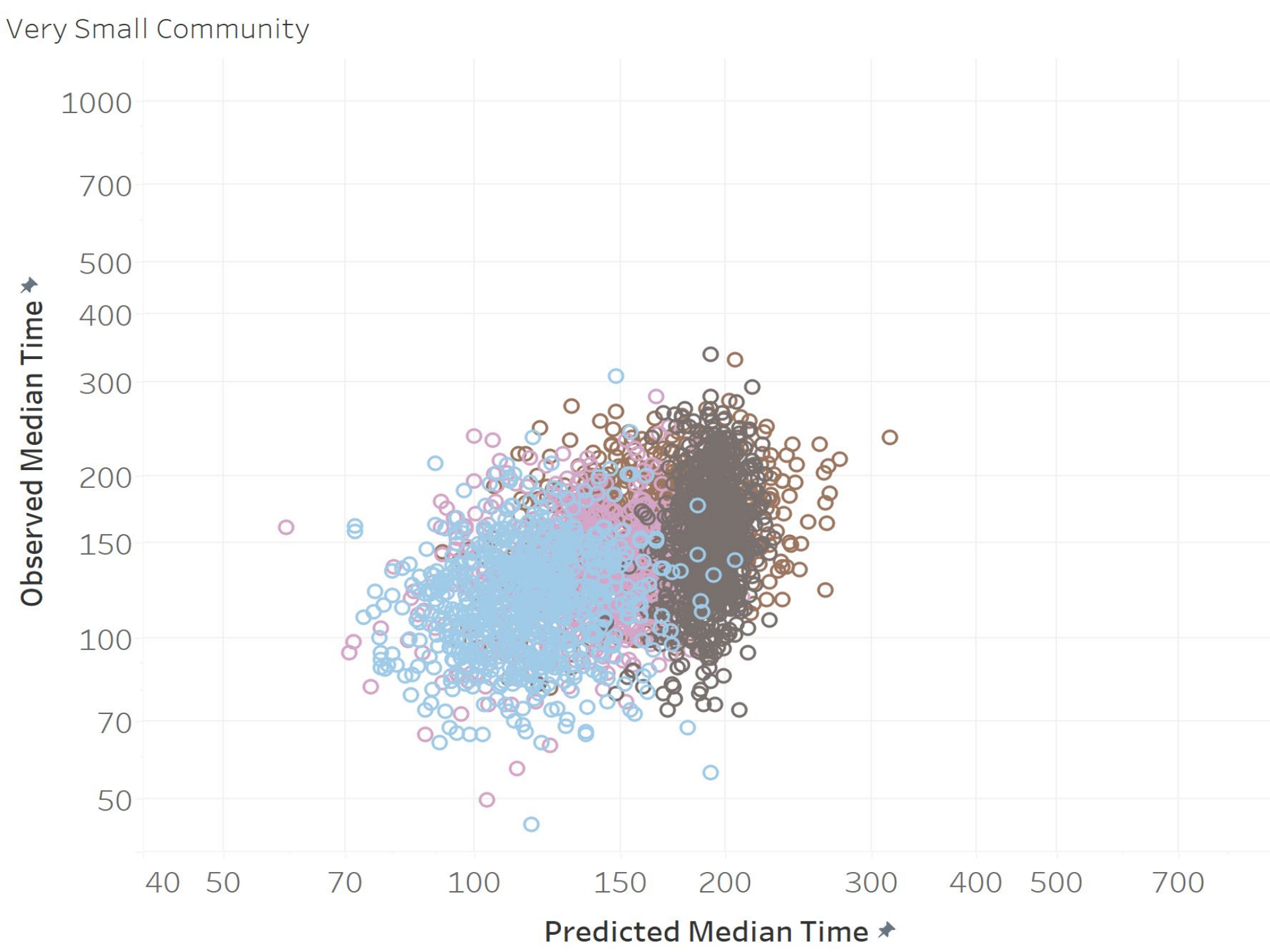
Academic Medical Center




Large Community
1000
700
500
400
300
200
150
100
70
50
Observed Median Time
40
50
70
100
150
200
300
400
500
700
Predicted Median Time

Small Community




Very Small Community
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Observed Median Time
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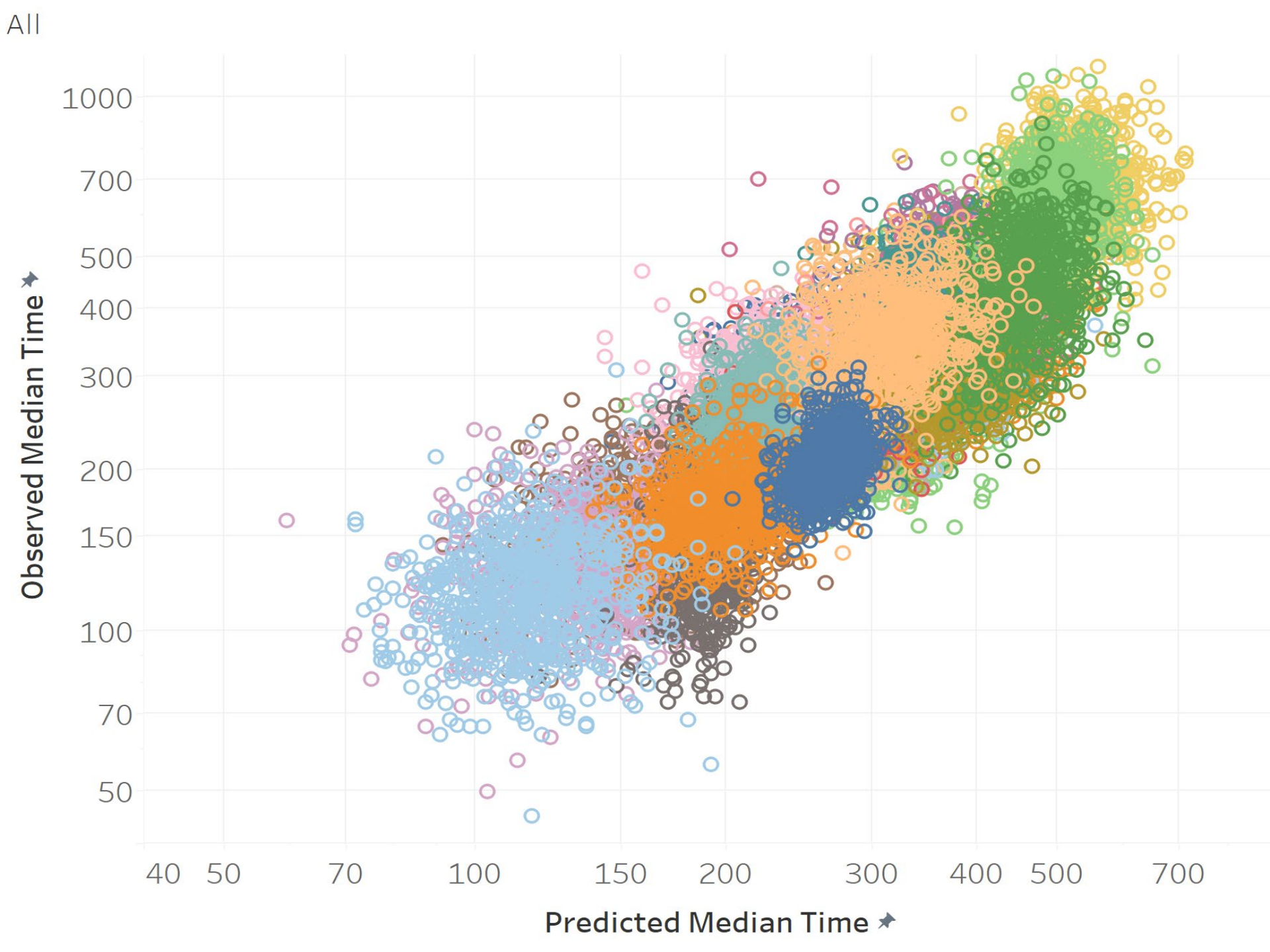
Predicted Median Time


All
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Observed Median Time
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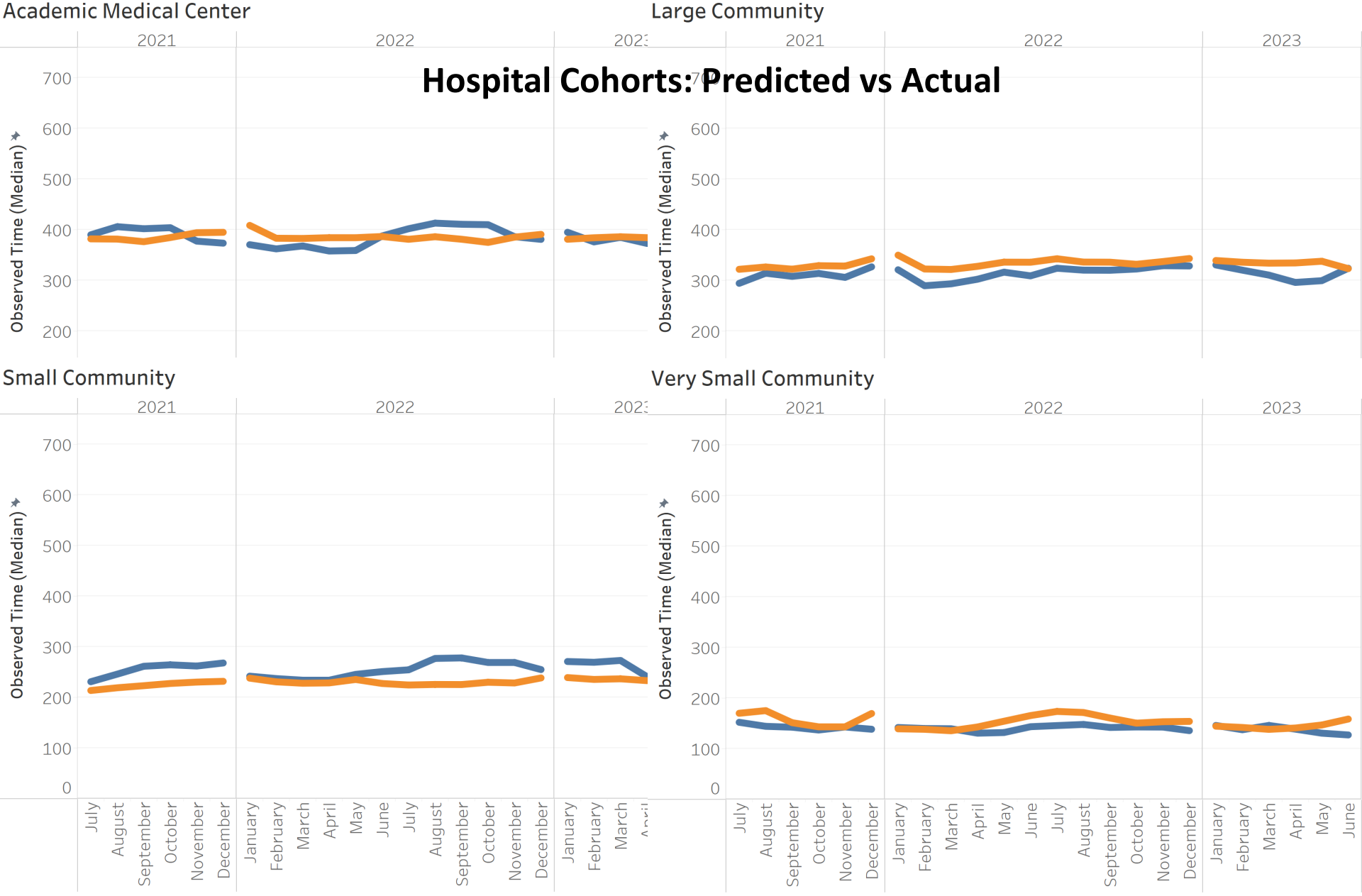
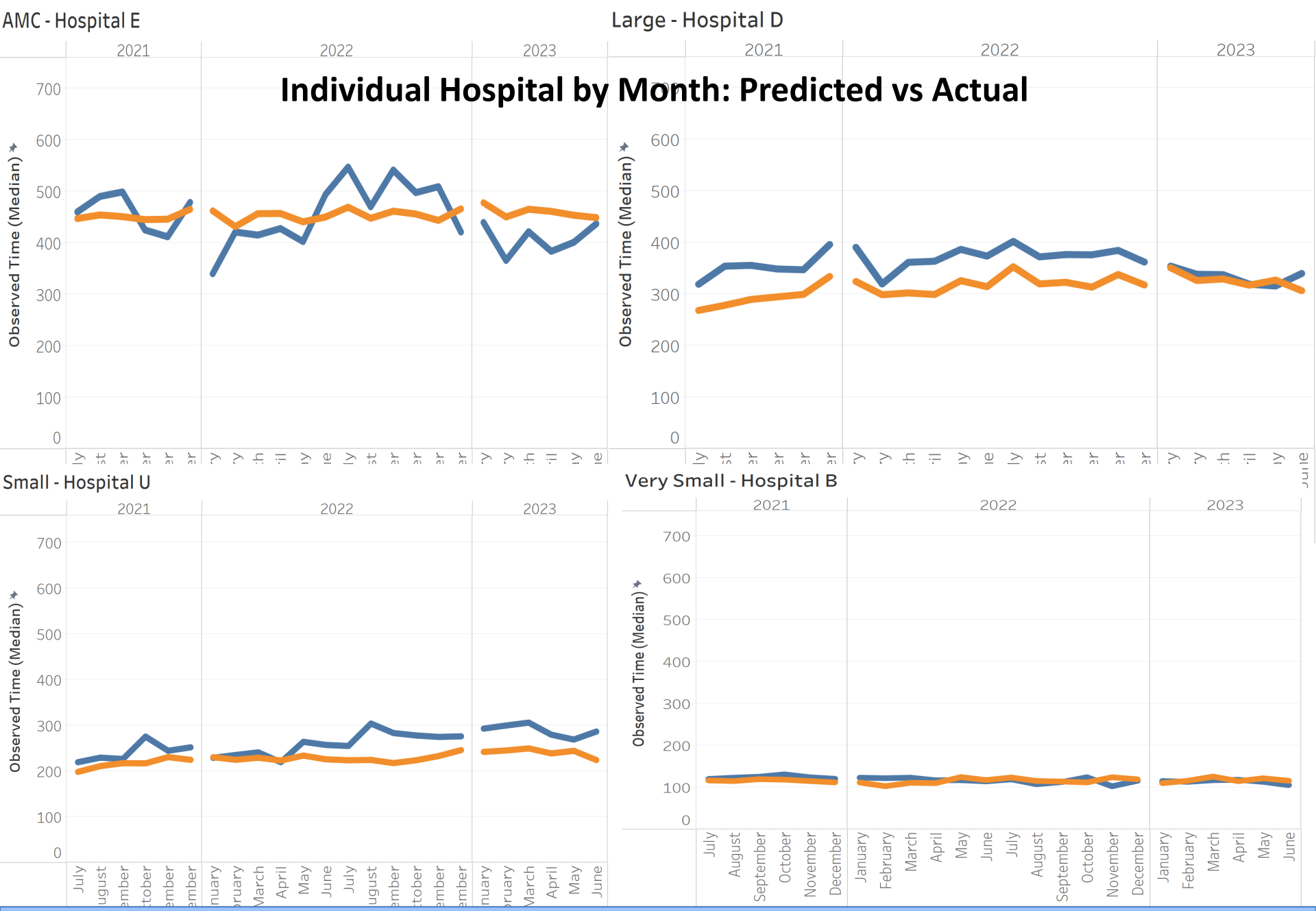
Predicted Median Time

Hospital Cohorts: Predicted vs Actual



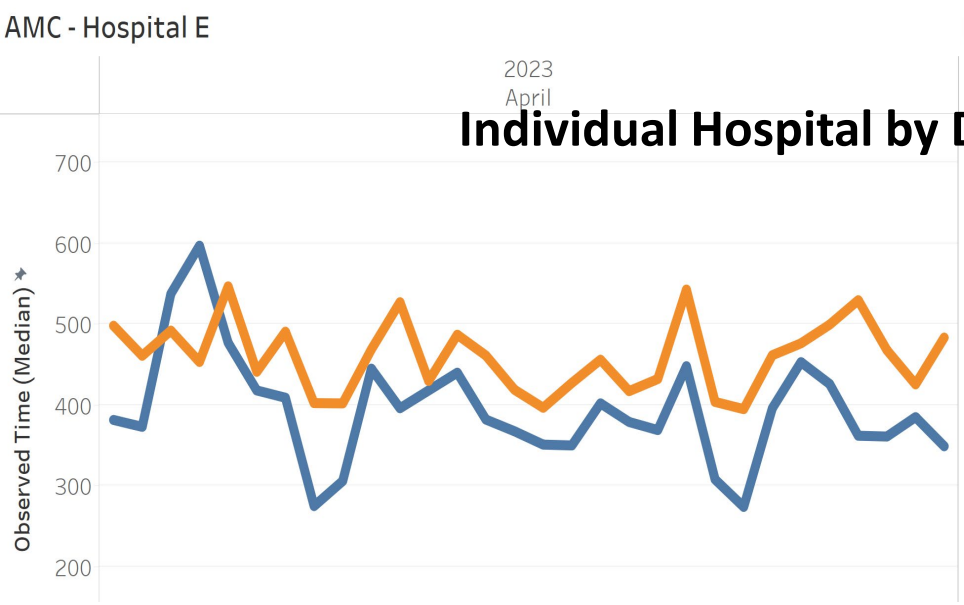
Low variability at the cohort level

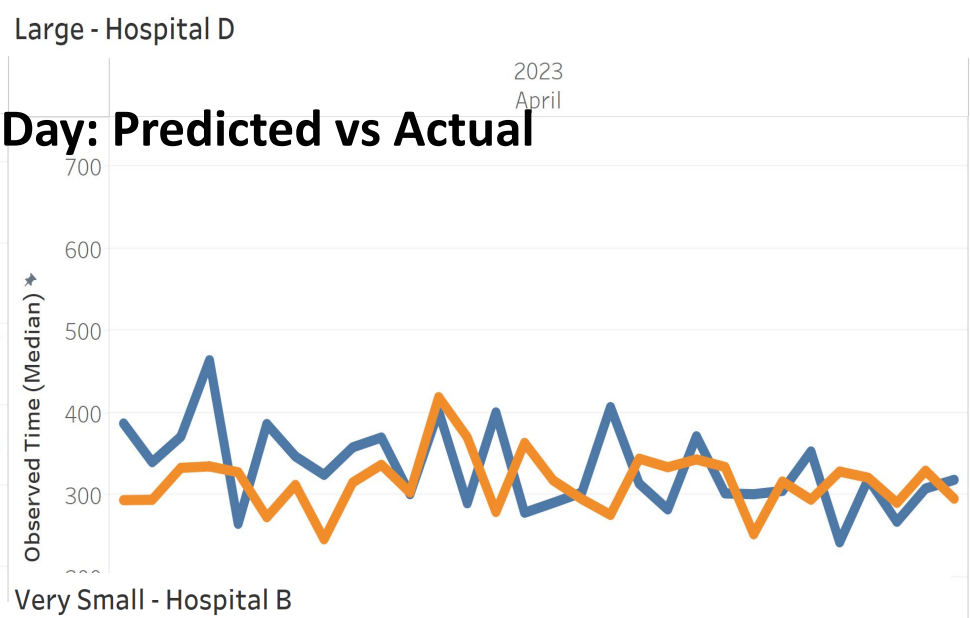
Individual Hospital by Month: Predicted vs Actual

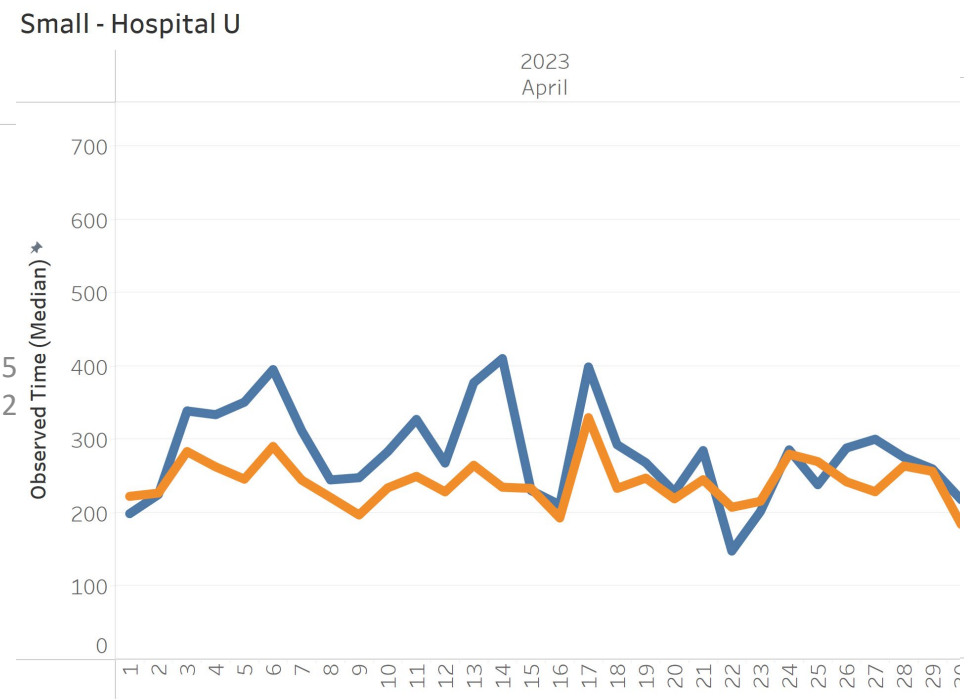


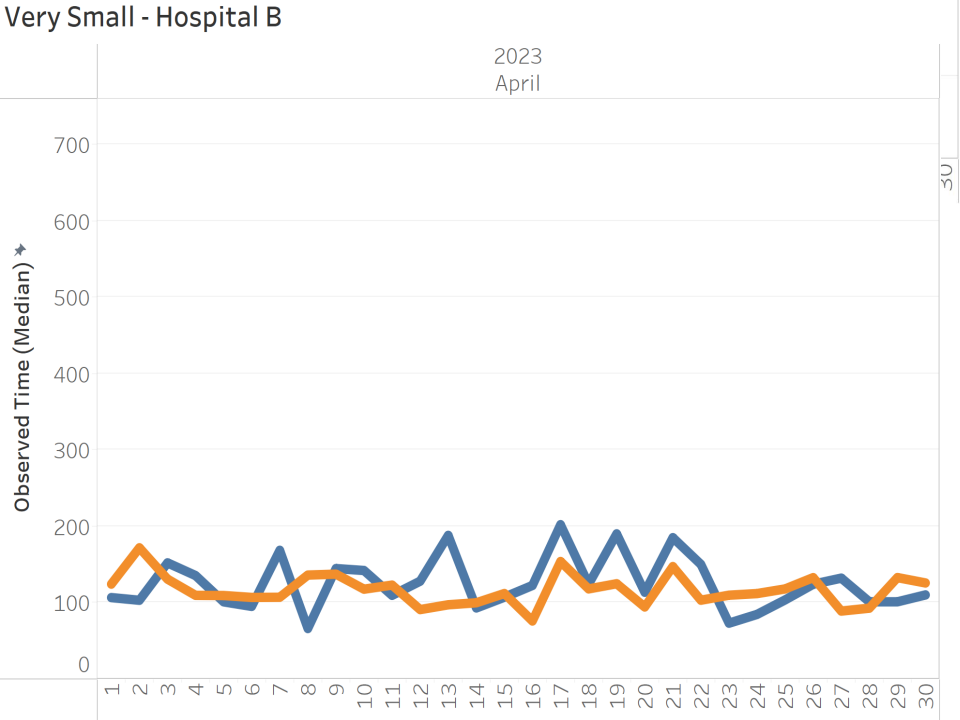
Low variability at the hospital level (Monthly)

Individual Hospital by Day: Predicted vs Actual









Expected variability at the hospital level BY DAY

Conclusion

Emergency Departments that care for patients with *more clinical and social needs* can expect *longer throughput times* than those who care for a population with fewer clinical and social needs.

AAEM
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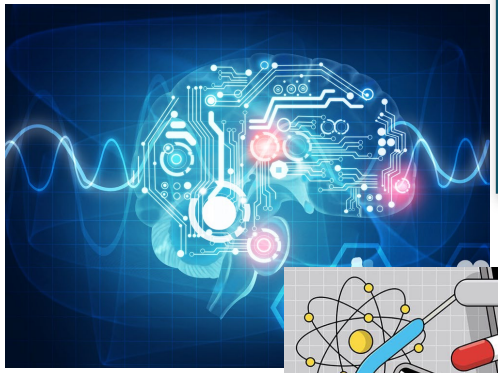
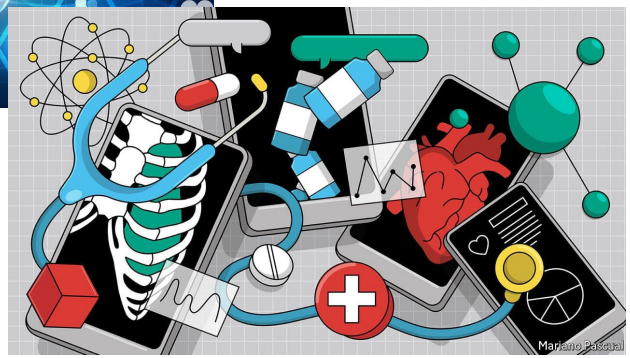
Patient Based Complexity Model

Use Case:

- Build a cohort
- Demonstrate comparison
- Observed over Expected

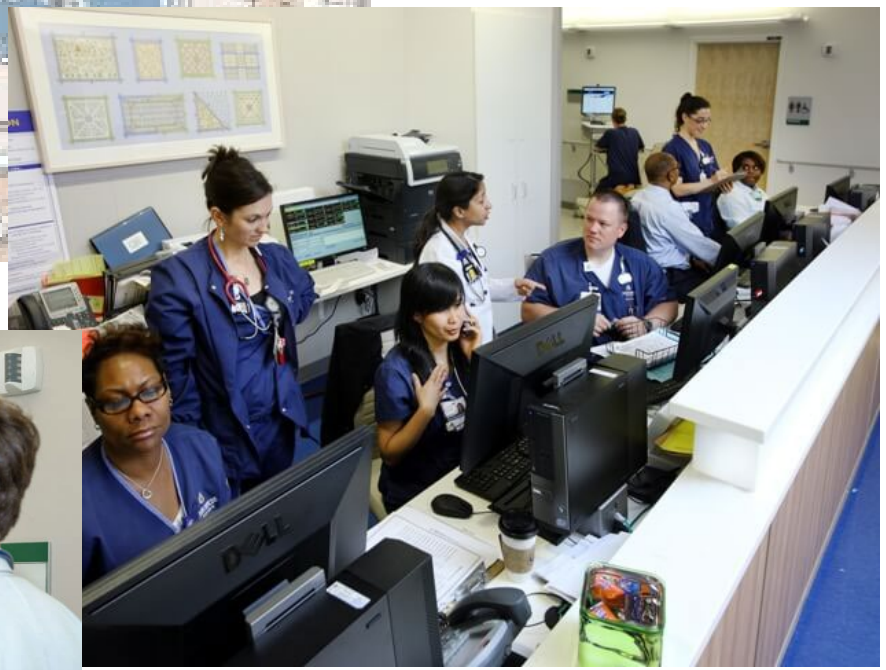




Next Steps:

- Finalize model
- *Add impact of boarding*
- Data access/Rollout

Implications



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THANK YOU

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Academy of Administrators in Academic Emergency Medicine

maryland
health services
cost review commission

Emergency Department and Hospital Throughput Best Practices Draft Policy

HSCRC Quality Program Goals

Implement standardized pay-for-performance programs that reward or penalize hospitals based on patient outcomes;

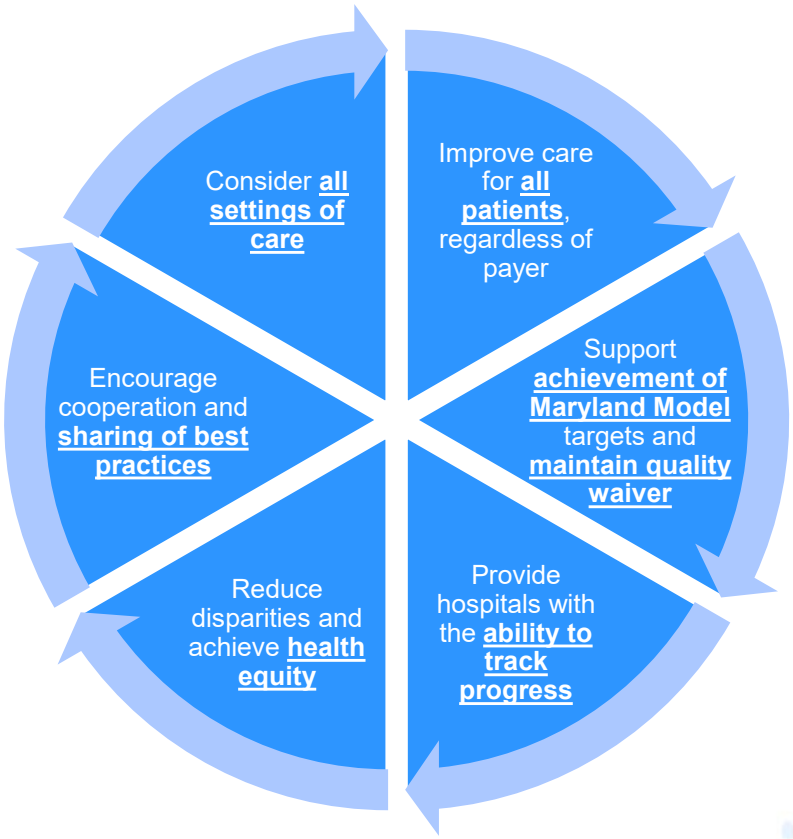
Utilize **a broad set of quality measures** that appropriately reflects the delivery of quality health care services provided at Maryland hospitals;

Provide timely and accurate year-to-date reports on quality performance using hospital case-mix data and other data sources;

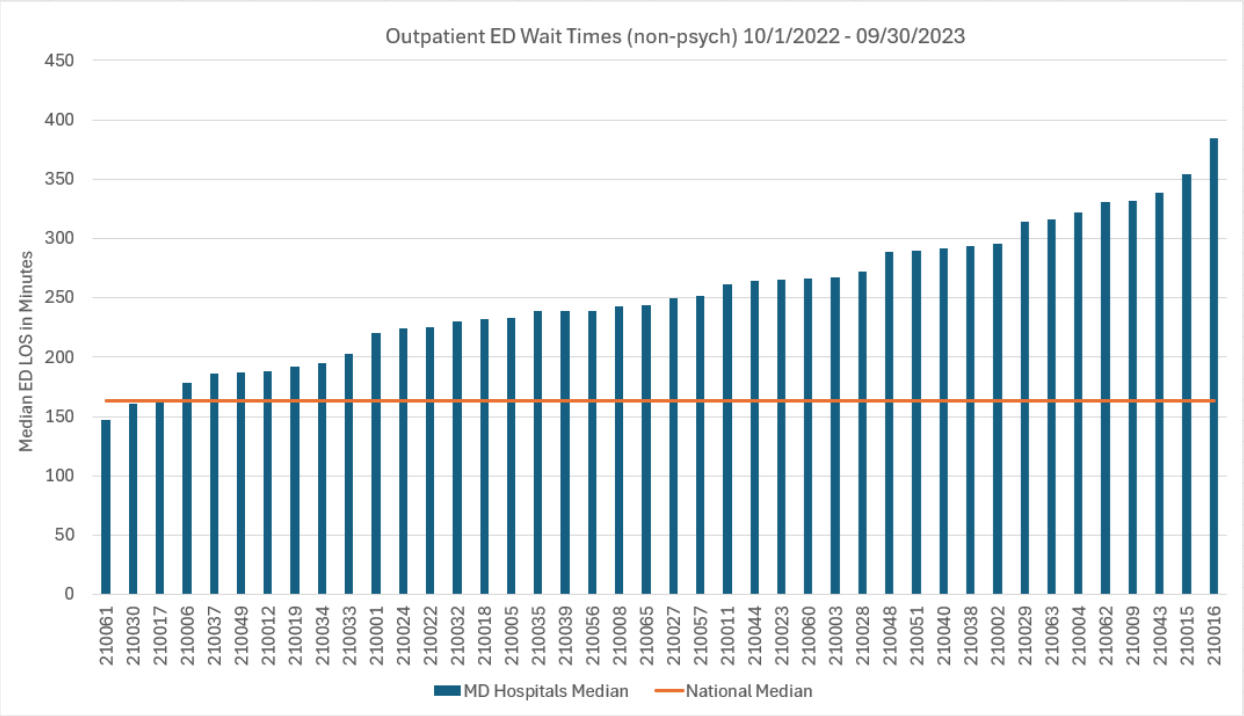
Align the incentives for enhancing health care quality in the hospital setting with **broader State health initiatives**.

HSCRC Quality Program Guiding Principles

- The mission of the HSCRC Quality Program is to create all-payer financial incentives for Maryland hospitals to provide efficient, high quality patient care, and to support delivery system improvements across the State.



Why Focus on Emergency Department Length of Stay?



maryland health services cost review commission

ED Best Practices Incentive Policy Development

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.

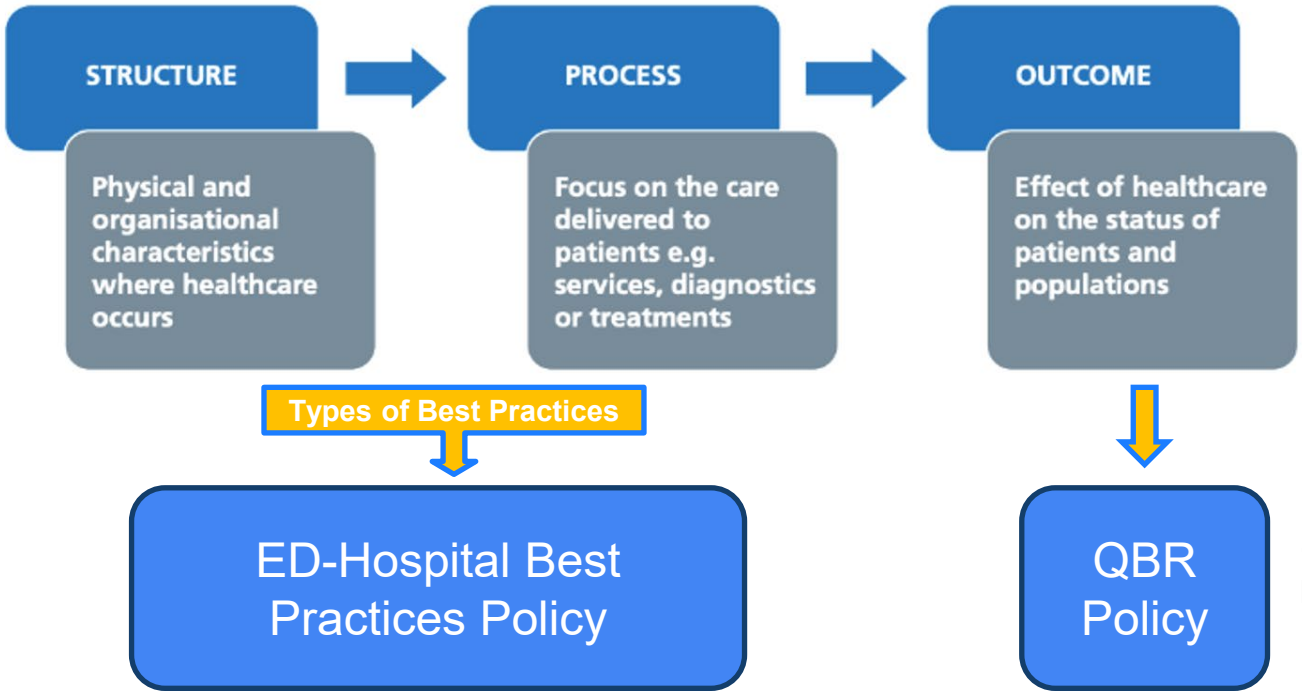
Steps

1. **Finalize a set of hospital best practices and tiers to improve overall hospital throughput and reduce ED length of stay**
2. **Develop data collection and auditing**
3. **Implement statewide monitoring reports**

RY 2027/CY 2025

4. Propose RY 2028 policy with revenue at-risk and scaled financial incentives

The Donabedian Model for Quality of Care



Draft Recommendations For RY 2027 (CY 2025 Performance Period)

Final Policy
February 2025

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    - For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice.

2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    - Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026.

3. We propose that subsequent rate years will have 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

Final Six Best Practices Selected

Each hospital will select 2 interventions from the 6 interventions below:

- Interdisciplinary Rounds
- Bed capacity Alert Process
- Standard Daily/Shift Huddles
- Expedited Care Bucket (inclusive of expediting team, rapid medical evaluation team, rapid medical evaluation unit and patient observation management)
- Patient Flow Throughput PI Council
- Establishing Clinical Pathways

Examples of Best Practice Measures and Tiers

Best Practice	Measures (EXAMPLE ONLY--Still in development)	Points (0-10 scale)
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.	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points
Bed Capacity Alert System	**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	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points
Standardized Daily/Shift Huddles	**TBD—**tier development and metrics in process, initial discussions focused on integrating ED census, wait time etc. into huddles, as well as linkage to interdisciplinary rounds	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points

Examples of Best Practice Measures and Tiers

Expedited Care Intervention (Expediting team, expedited care unit)	**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 **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**	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points
Patient Flow Throughput Performance Council	**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	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points
Clinical Pathways/Observation Management	**TBD: currently focused on evidence-based pathways that facilitate care across the continuum with overarching goal of enhancing and expediting care** **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** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points

Standard Daily Shift Huddles 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 and/or shift huddles utilizing a multidisciplinary team
- approach with a focus on throughput and discharges.
- **Tier 2:** Tier 1 requirements with the addition of 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 during huddles.
- Example KPIs could include but are not limited to:
  - the HCAHPS discharge domain, percent of discharge orders written by noon, or percent
  - patients leaving the facility by a designated time as determined by each facility.
  - Group discussion relating to barriers to these 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.

Commissioner Feedback on Best Practices Proposal for Discussion

- Consider simplifying tiers—can we design an overall measure with specific targets for each best practice?
- Request for brief justification of best practices selected-why the 2 were chosen for a particular hospital
- Consideration of MVP (Multi-Visit Patients) impact, will any of the best practices address MVP issues
- Discuss concerns regarding administrative burden and unintended consequences of measures
- Consider Best Practice work is a foundation for Quality Improvement Partnership

Next Steps

- Continue development of measure definition, tiers, and targets with hospital groups
- Comment period through 1/17
- Final policy presented to HSCRC Commission on 2/12