



maryland
health services
cost review commission

Performance Measurement Workgroup

January 15, 2025

HSCRC Quality Team

Meeting Agenda

- Stroke Misdiagnosis project
- RY 2027 Draft Readmissions Policy
- RY 2027 Draft MHAC Policy
- RY 2027 ED-Hospital Throughput Best Practices Policy

Workgroup Learning Agreements

- **Be Present** – Make a conscious effort to know who is in the room, become an active listener. Refrain from multitasking and checking emails during meetings.
- **Call Each Other In As We Call Each Other Out** – When challenging ideas or perspectives give feedback respectfully. When being challenged - listen, acknowledge the issue, and respond respectfully.
- **Recognize the Difference of Intent vs Impact** – Be accountable for our words and actions.
- **Create Space for Multiple Truths** – Seek understanding of differences in opinion and respect diverse perspectives.
- **Notice Power Dynamics** – Be aware of how you may unconsciously be using your power and privilege.
- **Center Learning and Growth** – At times, the work will be uncomfortable and challenging. Mistakes and misunderstanding will occur as we work towards a common solution. We are here to learn and grow from each other both individually and collectively.

REMINDER: These
workgroup
meetings are
recorded.

PMWG Members

Carrie	Adams	Meritus	Stephen	Michaels	MedStar Southern Maryland Hospital
Andrew	Anderson	Johns Hopkins Bloomberg	Lily	Mitchell	CareFirst
Ryan	Anderson	MedStar - MD Primary Care Program	Sharon	Neeley	Maryland Department of Health Medicaid
Kelly	Arthur	Qlarant QIO	Christine	Nguyen	Families USA
Ed	Beranek	Johns Hopkins Health System	Jonathan	Patrick	MedStar Health
Barbara	Brocato	Barbara Marx Brocato & Associates	Elinor	Petrocelli	Mercy Medical Center
Zahid	Butt	Medisolv Inc.	Mindy	Pierce	Primary Care Coalition of Montgomery County
Tim	Chizmar	MIEMSS	Nitza	Santiago	Lifebridge Health
Linda	Costa	University of Maryland School of Nursing	Dale	Schumacher	MedChi, Maryland State Medical Society
Ted	Delbridge	MIEMSS (c)	Madeleine "Maddy"	Shea	Health Management Associates
Toby	Gordon	Johns Hopkins Carey Business School	Brian	Sims	Maryland Hospital Association
Shannon	Hall	Community Behavioral Health Association of MD	Mike	Sokolow	University of Maryland Medical Systems
Theressa	Lee	Maryland Health Care Commission	Geetika "Geeta"	Sood	JHU SOM, Division of Infectious Diseases.
Stacy	Lofton	Families USA	April	Taylor	Johns Hopkins Health System
Angela	Maule	Garrett Regional Medical Center	Bruce	VanDerver	Maryland Physicians Care
Patsy	Mcneil	Adventist Health	Jamie	White	Frederick Health

Stroke Misdiagnosis in Dizzy Patients Project



JOHNS HOPKINS
M E D I C I N E

Armstrong Institute for Patient Safety and Quality

Avoid H.A.R.M.—ED Stroke/Dizziness

HSCRC Performance Measurement Workgroup
January 15, 2025

*Matt Austin, PhD
Associate Professor
Armstrong Institute for Patient Safety and Quality*

*Susan Peterson, MD
Associate Professor
Emergency Medicine*

The Problem



- Diagnostic error remains a major problem in public health
- An estimated 12M Americans are affected by diagnostic errors each year, with one in three errors leading to serious patient harm, including disability or death
- Three major disease categories—vascular events, infections, and cancer—account for $\frac{3}{4}$ of all serious harms from diagnostic error
 - **Missed stroke, a vascular event, is the leading cause of serious harm**
- Misdiagnosis of stroke disproportionately occurs when patients present with symptoms that are non-typical for stroke, such as dizziness or vertigo, which can easily be mistaken for inner ear disease
- Each year, an estimated 45-75K patients present to the ED with dizziness or vertigo caused by stroke that are misdiagnosed and erroneously discharged

Challenges to Improving Stroke Diagnosis



-
- **Lack of operationally viable performance measures:** Historically, measurement of diagnostic errors has required chart review
 - **Large evidence-to-practice gap:** ED patients with acute dizziness and vertigo could be correctly diagnosed as having a stroke if evidence-based interventions are followed

Overview of SPADE



- Symptom-Disease Pair Analysis of Diagnostic Error (SPADE) is a conceptual framework and methodological approach introduced by Liberman and Newman-Toker for uncovering misdiagnosis-related harms using “big data”, including large administrative, billing datasets
- The SPADE approach uses both look-back (case-control) and look-forward (cohort) methods to identify common symptoms that prompt a visit to a doctor, an urgent care center, or a hospital emergency department, and pairs them with one or more diseases that could be misdiagnosed in those clinical contexts
- Given the relatively low burden of mining administrative data sets, one of the primary potential applications of SPADE is in the measurement of diagnostic errors

Avoid H.A.R.M.—ED Stroke/Dizziness Measure



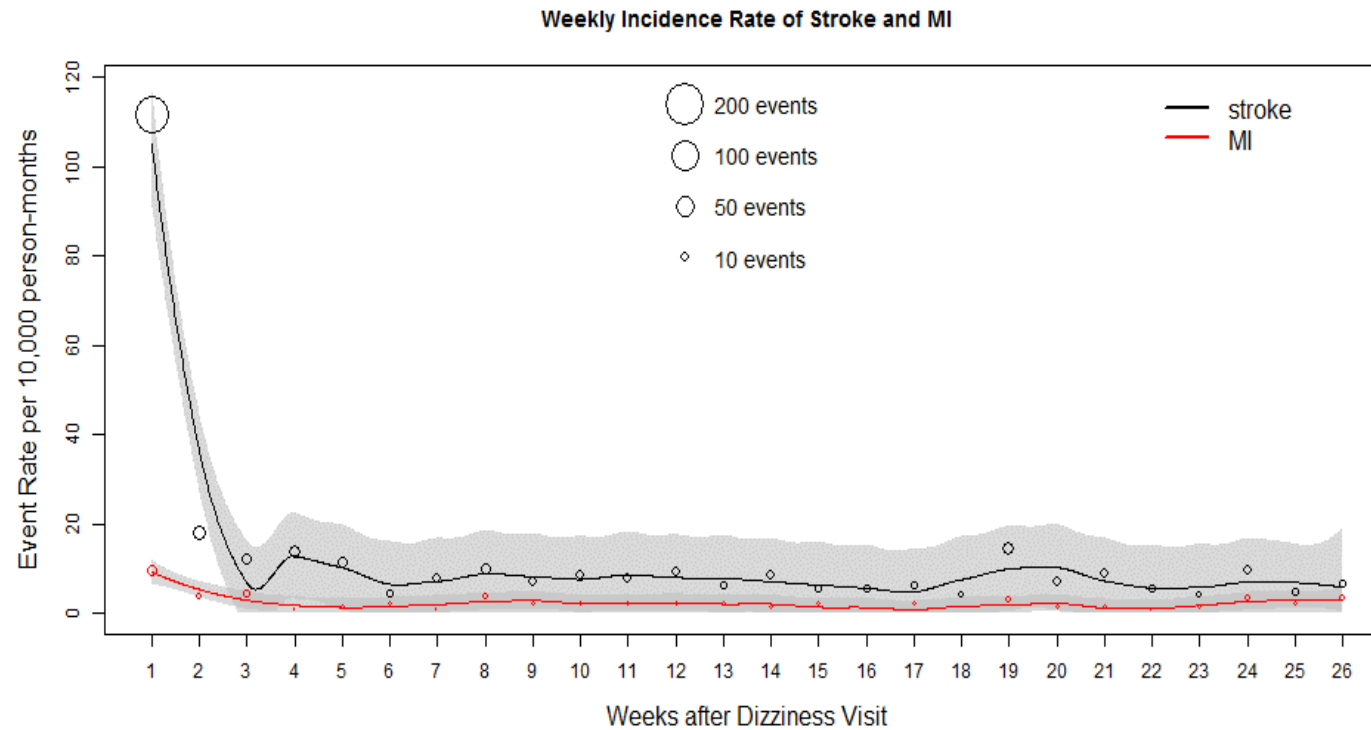
- Based on the SPADE methodology
 - Symptom-Disease Dyad: Dizzy (Symptom) - Stroke (Disease)
- Unit of measurement: Hospital ED
- Calculated using hospital claims
 - Have identified appropriate ICD-10 diagnosis codes for “benign dizziness” and stroke
- Designed as a 3-year measurement reporting period, to maximize reliability
 - Similar to reporting periods used for CMS mortality and readmission measures
- Measure was endorsed by Battelle’s PQM in December 2023
 - <https://p4qm.org/measures/3746>
 - Met endorsement criteria for evidence, scientific acceptability, feasibility, and usability
 - Received strong support from the stroke patient community

Measure Details



- **Measure denominator:** ED treat-and-release visits with a “benign dizziness” discharge diagnosis
- **Measure numerator:** Visits in the denominator are tracked after ED discharge to see if they were subsequently admitted to a hospital for a stroke within 30 days and within 360 days
- **Accounting for baseline risk:** Uses a risk difference approach, comparing the short-term incidence rate of stroke (reflecting days 0-30 post-ED visit) to the long-term incidence rate (reflecting days 91-360 post-ED visit)

	Days 0-30 “Observed” <small>Stroke Hospitalizations/10,000 ED Visits</small>	Days 91-360 “Expected” <small>Stroke Hospitalizations/10,000 ED Visits</small>	Attributable Rate O-E <small>Stroke Hospitalizations/10,000 ED Visits</small>
Hospital A	22.7	5.0	17.7
Hospital B	28.3	15.0	13.3

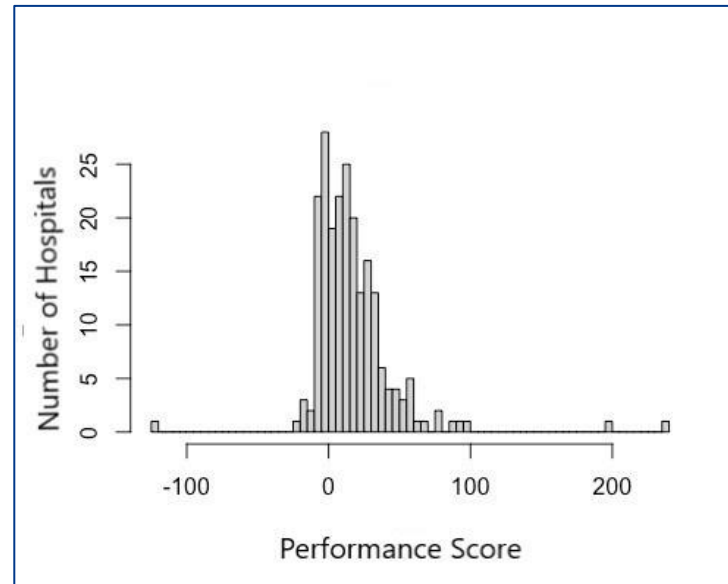


Weekly incidence rate curve of stroke hospitalizations post ED treat-and-release discharge as “benign dizziness.” Kaiser Permanente Mid-Atlantic data from the performance period from 2010-2014 at all outpatient sites (ED, ambulatory care). Data reflect 56,746 treat-and-release visits for “benign dizziness.” Shown in black are stroke hospitalizations, and shown in red are heart attack hospitalizations (for comparison). Gray shading represents 95% confidence intervals for each. **Early returns for stroke hospitalization above the epidemiologic base rate in the first few weeks after discharge reflect potentially preventable harms from stroke missed at the index visit.** The comparison outcome of heart attack demonstrates the association is specific for dizziness and stroke (i.e., absent for dizziness and heart attack).

Results for Florida Hospitals (Using HCUP Data)

- Used Florida HCUP Data
 - State Inpatient Database (SID)
 - State Emergency Department Database (SEDD)
- Data from Jan 1, 2016 – Dec 31, 2019
- 216 Hospital Emergency Departments

Histogram of Performance Scores



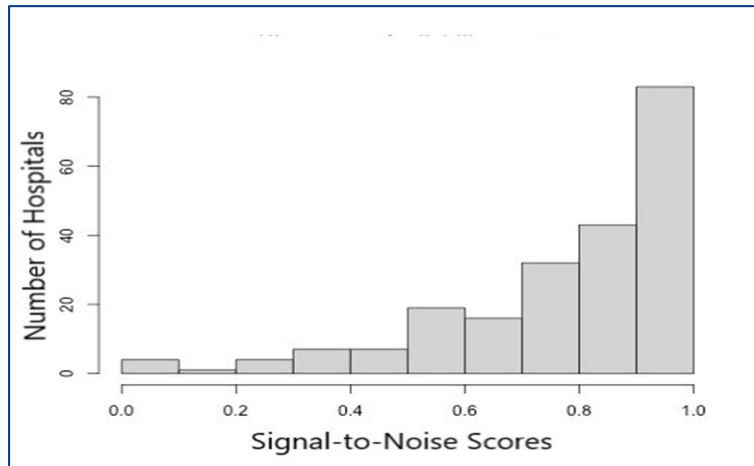
Attributable 30-day Stroke Harms Rate (per 10,000 dizziness discharges)

- Mean: 16.81
- Median: 11.27
- 25th Percentile: 0
- 75th Percentile: 26.92
- Standard Deviation: 29.86

Meaningful Differences

- 25.9% (n=56/216) were “better” than state average (upper bound of 95% CI < state average)
- 6.5% (n=14/216) had statistically significant “harm” (lower bound of 95% > 0)
- 0.9% (n=2/216) were “worse” than the state average (lower bound of 95% CI > state average)

Histogram of Signal-to-Noise Reliability Scores



Proposal



- HSCRC would calculate all-payer, Maryland hospital performance on the measure using HSCRC case-mix data and disseminate reports through CRISP
 - Input welcome on calculation frequency!
 - Proposed initial data time periods:
 - ED Visits: 1/1/2021-12/31/2023
 - Hospital Admissions: 1/1/2021 – 12/31/2024
- HSCRC would report back to each hospital their own performance on the measure and how they compared to other hospitals in the state (e.g., median, percentile, etc.)
- HSCRC would provide hospitals the list of cases that met the denominator and numerator criteria for purposes of QI
- We would be available to discuss measure and clinical issues with hospital stakeholders/clinicians as needed

What We Hope to Understand



- What are the barriers/challenges to calculating this measure across dozens of hospitals?
- How might we most effectively share data with hospitals to make the data meaningful/actionable for improvement?
- Are hospitals engaged in understanding their performance in this area of patient safety?
- Do we see unintended consequences that might point to the need for balancing or anti-gaming measures? (e.g., utilization of imaging, coding changes)
- Are there process measures (from the GRACE-3 guidelines) that could be feasibly calculated to accompany the intermediate outcome measure?

Draft RY 2027 Readmission Reduction Incentive Program Discussion

RRIP Update

Staff are no longer recommending extension of current policy for RY 2027

- Staff recommends that the RY 2027 draft policy address the following:
 - Updated base period for assessing improvement (i.e., 2022 vs 2023)
 - Revised improvement goal
 - Assessment of attainment goal
- Starting in RY 2028, the RRIP policy will align with statewide readmission goal under AHEAD. Specifically the measure definition and improvement targets are being developed for AHEAD between now and July 2025.
- Other items to address in future policies:
 - Observation Revisits
 - Out of State transfers and returns

Measuring Improvement

- Historically readmission improvement has been measured over multiple years with a fixed base (e.g., 2013-2018, 2018-2023)
 - This was to address concerns that hospitals may not be able to make incremental annual improvements and so that large improvements in one year that are maintained receive credit under the policy
 - Differs from how our other policies assess improvement
 - CMS HRRP program assesses attainment only, stratified by percent duals
- RY 2026 (CY 2024 performance) YTD indicates most hospitals have shown increases in readmissions between CY22 and CY24 (N = 27/43)

Selection of “Base” Year

Options: Stay with 2022 or move forward to 2023, or combined 2022-2023

- Staff has compared current results CY22-CY24 YTD with the following:
 - Use of CY 2022 and CY 2023 base combined
 - CY 2023 base
- If there are concerns about 2022, should there be changes to RY2026 policy as well?

Base Year	Statewide change in CY 2024	# of hospitals meeting improvement goal in CY2024	Net statewide revenue adjustments for improvement only
2022 with -2.53% improvement target	2.03%	11	~ -\$65M
2022 and 2023 with -2.53% improvement target	1.04%	13	~ -\$49M
2023 with -2.53% improvement target	-0.86%	16	~ -\$20M

CY2023 is base for many other financial methodologies and will most likely be base for AHEAD measures

Calculation of Attainment Goal

- Using RY 2026, staff assessing the impact of selecting the 65th percentile “point value” vs averaging hospitals within percentile ranges on the target
 - VBP and MHAC use the “average” for the benchmark
- Other option could be concurrent attainment (i.e., percentile during performance period) with national comparison
 - Simpler, but violates prospectivity, would be more or less aggressive depending on actual performance and relative changes national should be assessed.

CY22 with Out-of State Adjustment	Without improvement	With improvement*
65th percentile- 35th percentile for performance	11.31%	11.02%
Average of hospitals in top 70th percentile (similar to 35th percentile but not point estimate)	11.13%	10.85%

*Current policy adds in improvement target to attainment goal since attainment is calculated on “base” year

Improvement and Attainment Targets for Draft Policy

Staff are working with MEDA to update benchmarks to more recent years

- Staff plan to redo analyses used previously to set improvement goal from revised base (2022+2023, 2023)
- Updated Medicare FFS benchmarks will be available in time for draft policy, while commercial will be available by mid-February
- Staff will compare the readmission rate with improvement goal to the attainment standard to determine if 65th/35th percentile is reasonable and also explore the point estimate issue
- Staff will model out how much the attainment standard changes over time to understand impact of a concurrent attainment target (i.e., we could run it monthly on rolling 12 months during performance year, how much does it change over time) and think about comparison to national trends

Estimating Method	Percent Improvement from CY 2022 (11.15%)	Resulting Readm Rate (in 2026)
1. Annual 2018-2022 Improvement	-8.61%	10.19%
2. Annual 2021-2022 Improvement	-5.54%	10.53%
3. All hospitals to 2022 Median	-4.1%	10.69%
4a. Medicare Benchmarking - Peer County/MSA to 75th Percentile**	-4.75% to -5.45%	10.58%
4b. Commercial Benchmarking - Peer County/MSA to 75th Percentile**	-2.22% to -9.15%	10.58%
5. Reduction in Readmission-PQIs	-2.39%	10.88%

Next Steps

- Finalize analyses discussed today
- Present draft RY 2027 policy at February Commission meeting
 - Solicit comment letters
 - Present draft at February/March PMWG
 - Final policy will go to Commission April
- Staff leading work on establishment of statewide readmission goal for AHEAD
 - Will bring work plan with timeline to the February/March PMWG meeting

Draft RY 2027 MHAC Recommendations Discussion

MHAC Analysis



MHAC Analysis Overview

- / Rationale for testing PPC Composite Methodologies**
- / PPC Composite Options**
- / Results by Methodology**



Potential Benefits of PPC Composite Methodology

Concerns with Current MHAC Methodology	Benefit of PPC Composite Methodology
<p>Hospital performance may be based on as few as two or three of the fifteen payment PPC measures for small hospitals that do not meet the at-risk and expected PPC criteria for most PPC measures.</p>	<p>Hospital performance based on all or nearly all payment PPC measures because no longer requiring 20 at-risk discharges or 2 expected PPCs.</p>
<p>PPC measure reliability is very low for some of the 15 payment PPCs, especially for smaller hospitals.</p>	<p>Reliability of PPC composite is moderate to high, even for smaller hospitals.</p>
<p>Small hospital performance tends to be at the very top or the very bottom among Maryland hospitals.</p>	<p>Small hospital performance expected to be more stable across years because PPC composite has higher reliability, is based on hospital performance on all or almost all 15 payment PPC measures, and involves putting more weight on PPC measures for which the hospital has more at-risk discharges (or expected PPCs).</p>
<p>Two-years of data are used for small hospitals</p>	<p>Depending on PPC composite reliability results, the HSCRC could decide to use one-year of data for small hospitals or weight more recent year more heavily</p>



MHAC Analyses – PPC Composite Options

/ **The HSCRC tested how well three PPC composite methodologies address hospital concerns with the current MHAC methodology**

- PPC measures are implicitly or explicitly volume weighted such that PPC measures with more at-risk discharges (or expected PPCs) receive a larger weight in the composite
- PPC measures are also weighted by 3M Cost Weights (proxy for extent of harm PPC causes)
- Removed sufficient data requirement of at least 20 at-risk discharges and 2 expected PPCs such that performance on all or almost all of the 15 payment PPCs factor into a hospital's PPC composite score
- Calculate one threshold and one benchmark based on Maryland hospitals' PPC composite scores (instead of calculating a benchmark and threshold for each of the 15 PPC measures)



Differences Across MHAC Methodologies

Aspect	Current Methodology	PPC Composite Option 1	PPC Composite Option 2	PPC Composite Option 3
PPC Exclusion Criteria	Exclude PPC measures with <2 expected PPCs or <20 at risk discharges		Exclude PPCs with 0 at-risk discharges	
PPC Measure “Volume” Weights	PPC measures not weighted by volume	PPC measures with greater expected PPCs at hospital receive a larger weight	PPC measures with more at-risk discharges at hospital receive larger weight	PPC measures with more observed PPCs across Maryland hospitals receive a larger weight
PPC Measure 3M Cost Weights	PPC measures are weighted by 3M Cost Weights	In calculation of PPC composite O/E ratio, PPC measures are weighted by 3M Cost Weights		
Benchmarks and Thresholds	For each of the 15 payment PPCs, calculate a benchmark and threshold	Calculate a benchmark and threshold for the PPC Composite		



PPC Composite Option 1

- **Option 1:** Sum of hospital's observed PPCs divided by sum of expected PPCs across 15 payment PPCs, both numerator and denominator weighted by each PPC's 3M Cost Weight

$$PPC\ Composite_j = \frac{(\sum_{i=1}^{15} ObservedPPC_{ij} * 3MCostWeight_i)}{(\sum_{i=1}^{15} ExpectedPPC_{ij} * 3MCostWeight_i)}$$

- Does not explicitly weight PPC measures by volume, but PPC measures with higher expected PPCs receive more weight.
 - Expected PPCs increase as volume increases



PPC Composite Option 1: Hypothetical Example

Measure	Observed PPCs	Expected PPCs	3M Cost Weight	Observed PPCs *3M Cost Weight	Expected PPCs *3M Cost Weight
a	b	c	d	e= b*d	f=c*d
PPC 3	1	0.8854	0.3086	0.31	0.27
PPC 4	1	0.3681	1.1585	1.16	0.43
PPC 7	1	0.3633	1.2437	1.24	0.45
PPC 9	0	0.7421	1.2107	0.00	0.90
PPC 16	0	0.1777	1.4963	0.00	0.27
PPC 28	2	0.2618	0.4538	0.91	0.12
PPC 35	0	0.8612	1.2943	0.00	1.11
PPC 37	0	0.1986	1.6222	0.00	0.32
PPC 41	0	0.1187	1.0429	0.00	0.12
PPC 42	0	0.3982	0.4972	0.00	0.20
PPC 47	1	0.6237	0.8396	0.84	0.52
PPC 49	0	0.2251	0.4424	0.00	0.10
PPC 60	--	--	0.7592	--	--
PPC 61	--	--	0.1525	--	--
PPC 67	2	0.6709	1.1741	2.35	0.79
Total	8	5.8949	--	6.81	5.60

Measure	Unweighted O/E Ratio	At-Risk Discharges	Weighted O/E Ratio (Composite Score)
PPC Composite	1.36	7,118	(Sum of e / sum of f) = 1.21





PPC Composite Option 2

- **Option 2:** Sum of hospital's observed-to-expected (O/E) ratio for each PPC, weighted by the PPC measure's 3M Cost Weight and hospital's volume of at-risk discharges for given PPC measure

$$PPC\ Composite_j = \sum_{i=1}^{15} \left(\frac{Observed\ PPCs_{ij}}{Expected\ PPCs_{ij}} \right) * \left(\frac{Volume_{ij} * 3M\ Cost\ Weight_i}{\sum_{i=1}^{15} Volume_{ij} * 3M\ Cost\ Weight_i} \right)$$

- Volume = at-risk discharges for PPC measure (i) for hospital (j)
- For each hospital, the sum of the Volume-3MCostWeights across the 15 PPC measures equals 1



PPC Composite Option 2: Hypothetical Example

Measure	Unweighted O/E Ratio	At-Risk Discharges	3M Cost Weight	Volume*3M Cost Weight	Weight in Composite	Contribution to Composite
a	b	c	d	e = c*d	f = e/sum of e	g = b*f
PPC 3	1.13	534	0.3086	164.79	0.03	0.03
PPC 4	2.72	534	1.1585	618.64	0.10	0.28
PPC 7	2.75	762	1.2437	947.70	0.16	0.43
PPC 9	0.00	699	1.2107	846.28	0.14	0.00
PPC 16	0.00	459	1.4963	686.80	0.11	0.00
PPC 28	7.64	948	0.4538	430.20	0.07	0.54
PPC 35	0.00	280	1.2943	362.40	0.06	0.00
PPC 37	0.00	71	1.6222	115.18	0.02	0.00
PPC 41	0.00	131	1.0429	136.62	0.02	0.00
PPC 42	0.00	948	0.4972	471.35	0.08	0.00
PPC 47	1.60	366	0.8396	307.29	0.05	0.08
PPC 49	0.00	839	0.4424	371.17	0.06	0.00
PPC 60	--	0	0.7592	N/A ¹	N/A ¹	N/A ¹
PPC 61	--	0	0.1525	N/A ¹	N/A ¹	N/A ¹
PPC 67	2.98	547	1.1741	642.23	0.11	0.31
PPC Composite (Total)	1.36	7,118	--	6,100.66	1.00	1.67

Note: 1) PPC 60 and 61 excluded from composite and “sum of e” because hospital has 0 at-risk discharges for those PPCs.



PPC Composite Option 3

- **Option 3:** Sum of hospital's O/E ratio for each PPC, weighted by the PPC measure's 3M Cost Weight and hospital's volume of at-risk discharges for given PPC measure

$$PPC\ Composite_j = \sum_{i=1}^{15} \left(\frac{Observed\ PPCs_{ij}}{Expected\ PPCs_{ij}} \right) * \left(\frac{Volume_i * 3MCostWeight_i}{\sum_{i=1}^{15} Volume_i * 3MCostWeight_i} \right)$$

- For each hospital, the sum of the Volume-3MCostWeights across the 15 PPC measures equals 1



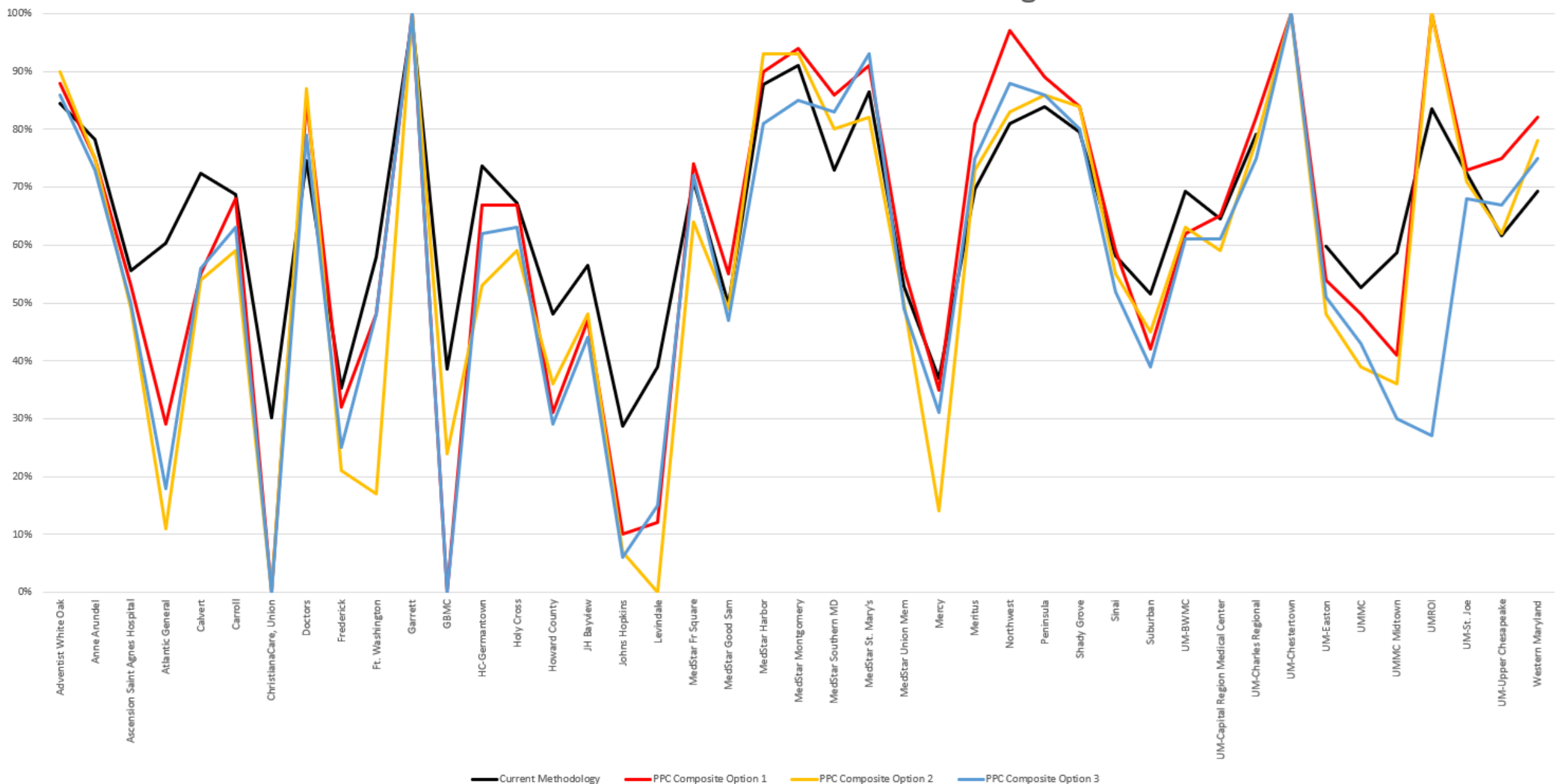
PPC Composite Option 3: Hypothetical Example

Measure	Unweighted O/E Ratio	Proportion of Observed PPCs Statewide	3M Cost Weight	Volume*3M Cost Weight	Weight in Composite	Contribution to Composite
a	b	c	d	e = c*d	f = e/sum of e	g = b*f
PPC 3	1.13	0.14	0.3086	0.04	0.05	0.05
PPC 4	2.72	0.05	1.1585	0.06	0.06	0.17
PPC 7	2.75	0.05	1.2437	0.07	0.07	0.20
PPC 9	0.00	0.13	1.2107	0.15	0.17	0.00
PPC 16	0.00	0.03	1.4963	0.04	0.04	0.00
PPC 28	7.64	0.05	0.4538	0.02	0.02	0.17
PPC 35	0.00	0.10	1.2943	0.13	0.14	0.00
PPC 37	0.00	0.06	1.6222	0.09	0.10	0.00
PPC 41	0.00	0.02	1.0429	0.02	0.02	0.00
PPC 42	0.00	0.12	0.4972	0.06	0.06	0.00
PPC 47	1.60	0.10	0.8396	0.08	0.09	0.15
PPC 49	0.00	0.03	0.4424	0.04	0.05	0.05
PPC 60	--	0.01	0.7592	N/A ¹	N/A ¹	N/A ¹
PPC 61	--	0.01	0.1525	N/A ¹	N/A ¹	N/A ¹
PPC 67	2.98	0.11	1.1741	0.13	0.14	0.43
PPC Composite (Total)	1.36		--			1.17

Note: 1) PPC 60 and 61 excluded from composite and “sum of e” because hospital has 0 at-risk discharges for those PPCs.



MHAC Results – MHAC Scores





MHAC Results - Correlations

Correlation	MHAC Score			
	Current Methodology	Composite Option 1	Composite Option 2	Composite Option 3
Current Methodology	1.00	0.92	0.92	0.87
Composite Option 1	--	1.00	0.96	0.92
Composite Option 2	--	--	1.00	0.87
Composite Option 3	--	--	--	1.00

Draft RY 2027 ED Best Practices Recommendations

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:

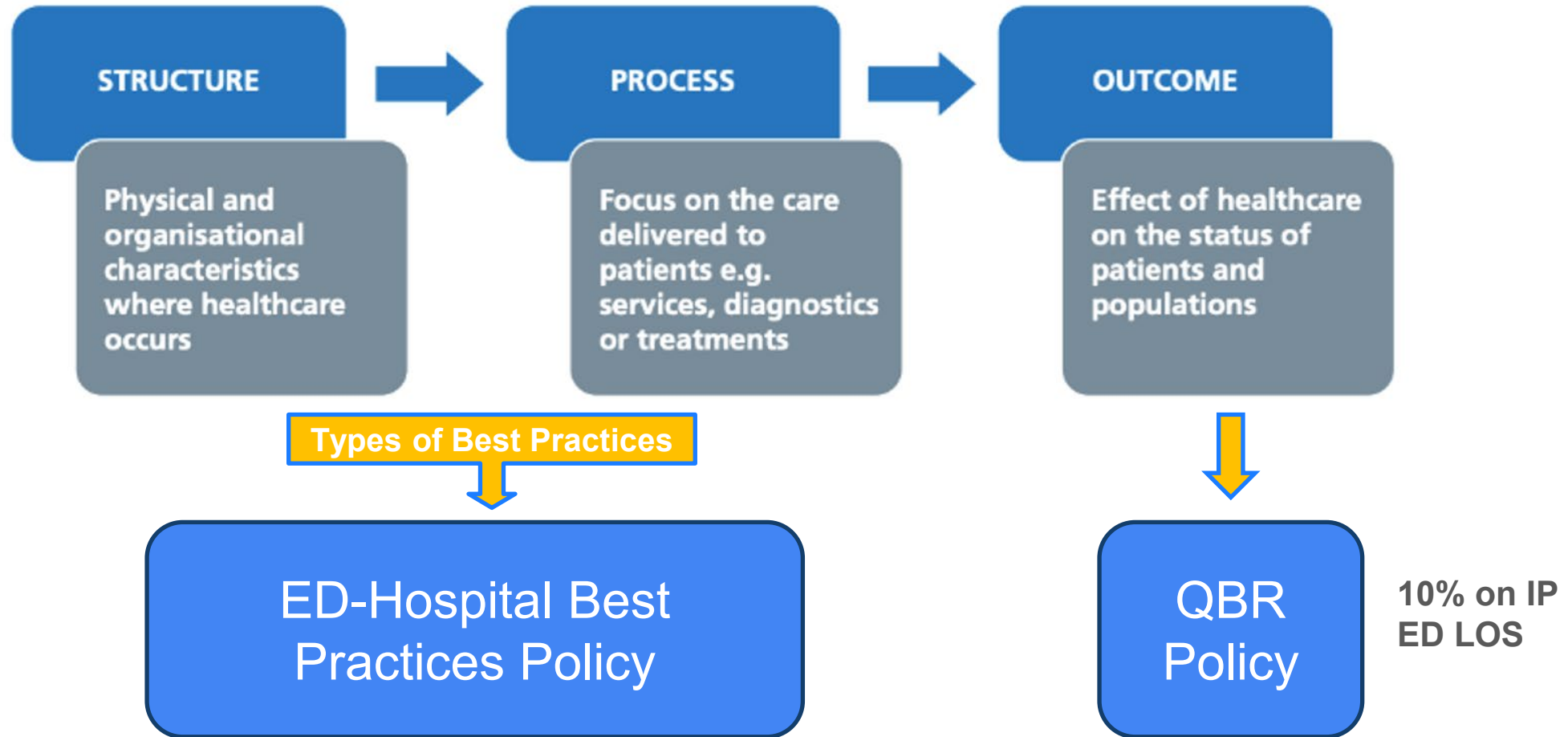
- Develop structural or process measures that will address systematically longer ED length of stay (LOS) in the State.
- Promote adoption of hospital best practices by providing GBR financial incentives.
- Align hospital initiatives with the goals of the ED Wait Time Reduction Commission.

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

RY 2027/CY 2025

The Donabedian Model for Quality of Care



DRAFT RECOMMENDATIONS FOR RY 2027 (CY 2025 PERFORMANCE PERIOD)

Final Policy
March 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	<p>Tier 1: Interdisciplinary Rounds piloted with a target of x% on at least 1 unit</p> <p>Tier 2: Interdisciplinary Rounds implemented on X additional units AND documentation of discharge planning initiated Day 1</p> <p>Tier 3: Leadership involvement in Interdisciplinary Rounds</p> <p style="text-align: center;">OR</p> <p>Documentation of prior auth for post-acute placement by x timeframe; specialist consults completed within 24 hours of order, etc.</p>	<p>Tier 1 earns 0-2 points</p> <p>Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points)</p> <p>Tier 3 earns up to 4 additional points</p>
Bed Capacity Alert System	<p>Tier 1: Bed capacity Alert triggered at a certain surge level, alert goes to all inpatient and outpatient areas And triggers mandatory leadership huddles</p> <p>Tier 2: Bed capacity alert includes non-hospital partners (outpatient providers, local post-acute facilities)</p> <p>Tier 3: Leverage Access centers and CRISP to facilitate most appropriate patient placement; potentially partner with MIEMSS long-term</p>	<p>Tier 1 earns 0-2 points</p> <p>Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points)</p> <p>Tier 3 earns up to 4 additional points</p>
Standardized Daily/Shift Huddles	<p>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</p>	<p>Tier 1 earns 0-2 points</p> <p>Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points)</p> <p>Tier 3 earns up to 4 additional points</p>

Examples of Best Practice Measures and Tiers

<p>Expedited Care Intervention (Expediting team, expedited care unit)</p>	<p>Proposal 1: select one or more of multiple expediting practices</p> <p><u>Nurse expediter</u></p> <p>Tier 1: Designated RN for admission/discharge planning/coordination</p> <p>Tier 2: Tier 1 & x% decrease in discharge order to discharge time for D/C to Home pts</p> <p>Tier 3: Tier 1 & 2 plus (x+5% decrease in discharge order time for D/C to Home</p> <p><u>Discharge Lounge</u></p> <p>Tier 1: Designated clinical space & staff to discharge patients from a Discharge lounge</p> <p>Tier 2: Tier 1 & (x%) decrease to discharge order to discharge time</p> <p>Tier 3: Tier 1, 2 & (x+5%) decrease in discharge order to discharge time</p> <p><u>Observation Unit</u></p> <p>Tier 1: Dedicated clinical space and staffing for short stay patients</p> <p>Tier 2: Tier 1 & Decrease in Total Obs (ED Obs & Hospital Obs) LOS</p> <p>Tier 3: Tier 1 & 2 & (x+5%) Decrease in Total Obs LOS</p> <p>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</p>	<p>Tier 1 earns 0-2 points</p> <p>Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points)</p> <p>Tier 3 earns up to 4 additional points</p>
<p>Patient Flow Throughput Performance Council</p>	<p>Tier 1: Established Patient Flow Throughput Performance Council with front-line and leadership representation, meets at least monthly</p> <p>Tier 2: Council tracks and implements specific interventions targeted at decreasing inpatient LOS</p> <p>Tier 3: Leadership has strategic goals for each department tied to patient flow throughput</p>	<p>Tier 1 earns 0-2 points</p> <p>Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points)</p> <p>Tier 3 earns up to 4 additional points</p>
<p>Clinical Pathways/Observation Management</p>	<p>TBD: currently focused on evidence-based pathways that facilitate care across the continuum with overarching goal of enhancing and expediting care</p> <p>Example: Chest pain protocol that leverages nurse driven protocol and/or expedited evaluation in an outpatient setting if clinically appropriate & expedited protocol for inpatients.</p>	<p>Tier 1 earns 0-2 points</p> <p>Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points)</p> <p>Tier 3 earns up to 4 additional points</p>

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 2/19
- Final policy presented to HSCRC Commission at March Commission meeting



THANK YOU!

Next Meeting: February 19, 2025
