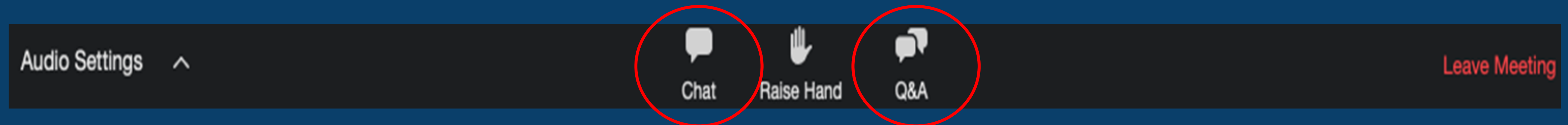
Helping improve the health of Michigan through sustainable, high-value healthcare

MVC Virtual Semi-Annual Meeting

May 7th, 2021

Housekeeping

- Please ask any questions through the Zoom Q&A function
  - In doing so, please provide your name and hospital/PO affiliation
  - We will do our best to answer some of these questions in the Q&A function, and at the end of each section
- MVC Component of the BCBSM P4P Program PY21 Bonus Point
  - If you are dialing in from a cell or didn't enter your details on admission to the meeting, please add your name and institution in the chat
- Please also complete the MVC/BCBSM post meeting survey



MVC Michigan Value Collaborative

Blue Cross Blue Shield Blue Care Network of Michigan

Acknowledgements

- Welcome hospital and physician organization leaders/staff, and first time attendees!
- Today's speakers:

Organization	Speakers
Blue Cross Blue Shield of Michigan	• Dr. James Grant, MD, MBA, FASA
Spectrum Health Lakeland St. Joseph Niles	• Dr. Rob Nolan, DO • Michael Getty, MBA
Consortium of Independent Physician Association & Professional Medical Corporation	• Kyle Enger, PhD, MPH
Michigan Emergency Department Improvement Collaborative	• Dr. Keith Kocher, MD, MPH

Agenda

Welcome and MVC Updates	10:00am – 10:15am
BCBSM: Introducing new CMO Dr. James Grant	10:15am – 10:25am
Setting the Scene: Transition Variations in Michigan Hospitals	10:25am – 10:35am
Spectrum Health Lakeland St. Joseph Niles: ED and Readmissions	10:35am – 10:45am
Question and Answer	10:45am – 10:50am
How CIPA and PMC Support PCPs in Promoting Appropriate Emergency Care.	10:50am – 11:00am
Question and Answer	11:00am – 11:05am
Michigan Emergency Department Collaborative (MEDIC)	11:05am – 11:15am
Question and Answer	11:15am – 11:20am
Next Steps	11:20am – 11:30am

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Blue Cross Blue Shield Blue Care Network of Michigan

MVC Updates

- Welcome new MVC collaborative members
  - ➢ Alcona Health Center
  - ➢ Ascension Borgess Allegan Hospital
  - ➢ Helen Newberry Joy Hospital
  - ➢ Hills and Dale General Hospital
  - ➢ Munson Healthcare Otsego Memorial Hospital
  - ➢ Munson Healthcare Charlevoix Hospital
  - ➢ Marlette Regional Hospital
  - ➢ McKenzie Health System
  - ➢ Scheurer Health
  - ➢ Schoolcraft Memorial Hospital
  - ➢ Three Rivers Hospital

- New MVC Coordinating Center Members
  - ➢ Jeff Jameel: MVC Site Engagement Coordinator:
  - ➢ Brad Raine: MVC Analyst

MVC Updates

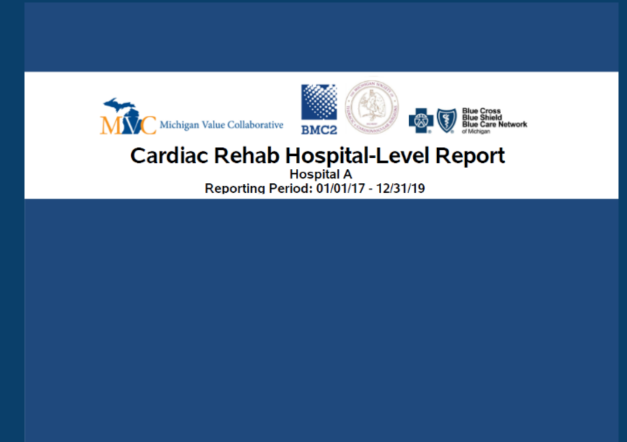
Medicaid data added to MVC data sources

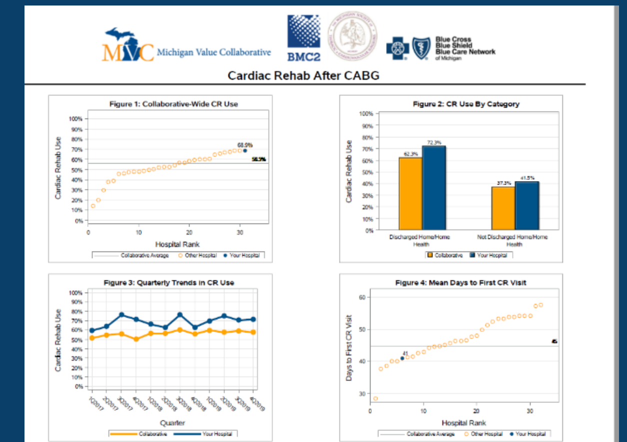
Increased collaborative membership

New push reports launched

MVC Component of BCBSM P4P Program PY20

Qualified Entity Certification Program Approval





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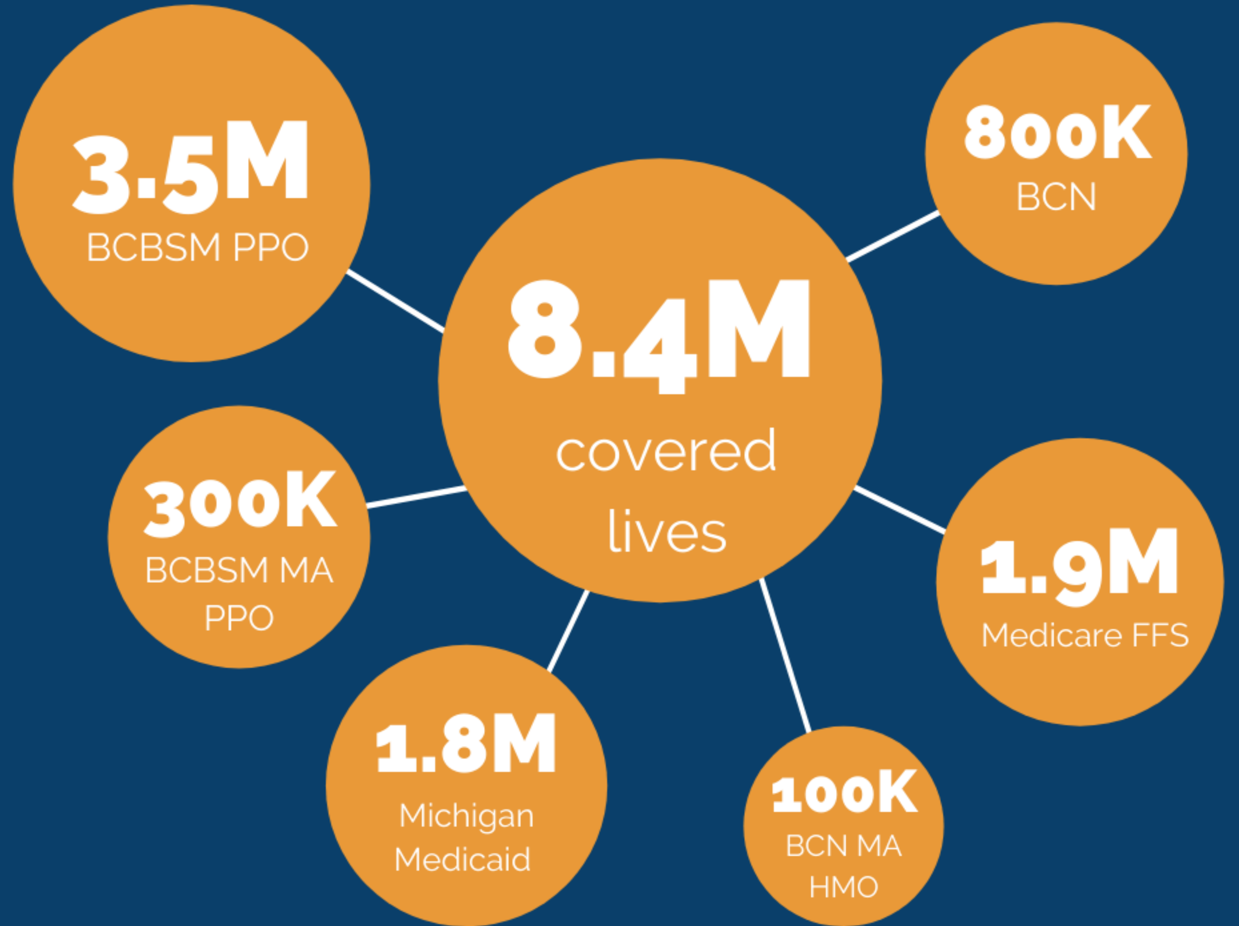
DATA SOURCES

MVC DATA SOURCES COMPRISE

>80%

OF MICHIGAN'S INSURED POPULATION



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Blue Cross Blue Shield Blue Care Network of Michigan

Number of MVC Episodes by Payer

Payer	Number of Episodes (Thousands)
Medicare	609k
BCBSM PPO Commercial	353k
Medicaid	311k
BCBSM PPO Medicare Advantage	184k
BCN HMO Commercial	113k
BCN HMO Medicare Advantage	47k

Reporting Period for Index Admissions
Medicare: 1/1/15 – 12/31/19
Medicaid: 1/1/15 – 9/30/19
BCBSM/BCN Products: 1/1/15 – 12/31/20

Proportion of Medicaid Episodes by Hospital

Proportion of Medicaid Episodes

60%
50%
40%
30%
20%
10%
0%

0 10 20 30 40 50 60 70 80 90 100

MVC Hospital

Reporting Period
Medicaid: Index Admissions 1/1/15 – 9/30/19

Top 5 Medicaid Conditions

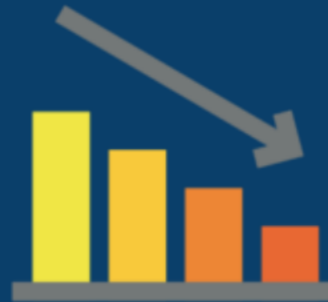
Rank	Condition	Count of Medicaid Episodes
1	Sepsis	39k
2	C-section	38k
3	Vaginal Delivery	30k
4	Cholecystectomy	22k
5	COPD	18k

Reporting Period
Medicaid: Index admissions 1/1/15 – 9/30/19

MVC Component of the BCBSM P4P Program

P4P Program Year 2020 Overview

Average Points Earned	Total Estimated Payment Reduction	Highest Earning Condition
5.5 Points	$5.7 Million	Joint Replacement: 4.1 Points, $3.5 Million



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Program Year 2020 Score Distribution

Points	Hospitals
0	9
1	1
2	5
3	7
4	3
5	11
6	8
7	8
8	7
9	8
10	8

Average Points Earned: 5.5

MVC Component of BCBSM P4P Program: PY21

- Remember, for PY21 only, two participation based bonus points are available:

Program Year 2021 Participation Bonus Points	
Attend **BOTH** MVC Semi-Annual Events	1 P4P Bonus Point
Schedule & Complete 1 Virtual/In-Person Site Visit	1 P4P Bonus Point

- To schedule a site visit, click here: https://app.acuityscheduling.com/schedule.php?owner=21303482

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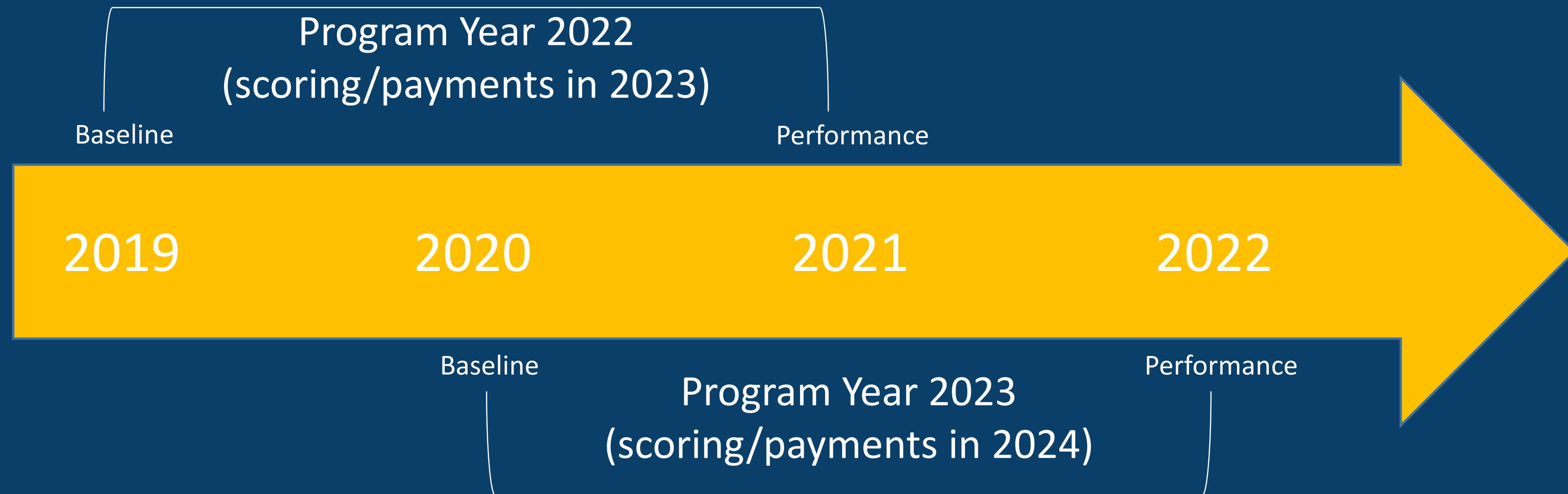
MVC Component of BCBSM P4P Program PY22 & PY23



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PY22 & PY23: What is staying the same?

Metric	Maximum Score	Condition Options
Risk-adjusted, price-standardized total episode payments	10	Choose 2 of 7: CABG, Spine, Joint, COPD, Pneumonia, CHF, Colectomy
Scoring Logic	**Improvement Comparison**	**Achievement Comparison**
Still awarded greater of the two, either Improvement or Achievement	Improvement based on hospital's own past performance	Achievement based on comparison to MVC cohort

PY22 & PY23: What is changing?

Methodological Changes

- Improvement and Achievement equations will become more similar and be placed on the same scale
- Achievement will no longer be based on *rank within cohort*, but *distance from cohort mean*

Bonus Point Changes

- Bonus points no longer given for 5% cohort reduction
- Bonus points available for completing qualitative questionnaire per condition (2 total points possible)

Changes for PY22 & PY23: More Details to Come

- Service line selection reports for PY22 & PY23 will be shared with the collaborative in the next month

- Members will be given three weeks to return their selections

- To support this, two dedicated P4P webinars will be held.
- More details to follow.

BCBSM: Introducing Dr. James Grant

Setting the Scene: Transition Variations in Michigan Hospitals

Collaborative-Wide Risk-Adjusted Total Episode Spending

	Index	Post-Discharge	Professional	Readmission
Average Payment for Medical Service Line	$12,530	$3,295	$2,824	$2,670

Reporting Period: Index Admissions from 1/1/17 - 12/31/19

Data Source: MVC 30-day episodes from Medicare FFS, BCBSM PPO Commercial, BCN Commercial, BCBSM PPO MA, and BCN MA

Collaborative-Wide Risk-Adjusted Post-Discharge Spending

Average Payment

	Average Payment
SNF	$1,432
OP Other	$651
IP Rehab	$407
Home Health	$359
Emergency Department	$303
OP Rehab	$42

Reporting Period: Index Admissions from 1/1/17 - 12/31/19

Data Source: MVC 30-day episodes from Medicare FFS, BCBSM PPO Commercial, BCN Commercial, BCBSM PPO MA, and BCN MA

Collaborative-Wide Variation in Average ED Payment

ED Payment

$2,800
$2,600
$2,400
$2,200
$2,000
$1,800
$1,600
$1,400
$1,200
$1,000

Mean: $2,000

1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51 53 55 57 59 61 63 65 67 69 71 73 75 77 79 81

Hospital Rank

MVC All　MVC Hospitals

Reporting Period: Index Admissions from 1/1/17 - 12/31/19

Data Source: MVC 30-day episodes from Medicare FFS, BCBSM PPO Commercial, BCN Commercial, BCBSM PPO MA, and BCN MA

Collaborative-Wide Variation in ED Utilization

Reporting Period: Index Admissions from 1/1/17 - 12/31/19

Data Source: MVC 30-day episodes from Medicare FFS, BCBSM PPO Commercial, BCN Commercial, BCBSM PPO MA, and BCN MA

Frequency of ED Visits

15%

ED Utilization Rate

99% had **one** visit

1% had **multiple** visits

Reporting Period: Index Admissions from 1/1/17 - 12/31/19

Data Source: MVC 30-day episodes from Medicare FFS, BCBSM PPO Commercial, BCN Commercial, BCBSM PPO MA, and BCN MA

Days Until First ED Visit

Days until first ED visit	Proportion of ED Visits
0 days	6.1%
1-3 days	13.5%
4-7 days	14.3%
8-14 days	21.9%
15-30 days	44.2%

Reporting Period: Index Admissions from 1/1/17 - 12/31/19

Data Source: MVC 30-day episodes from Medicare FFS, BCBSM PPO Commercial, BCN Commercial, BCBSM PPO MA, and BCN MA

Top Reasons for ED Visit

COPD

18.5%

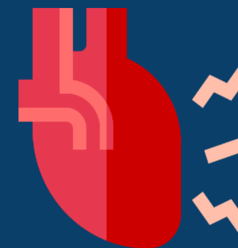
Chronic obstructive pulmonary disease w/ acute exacerbation

Stroke

12.1%

Cerebral infarction, unspecified

AMI



9.5%

Non-ST elevation (NSTEMI) myocardial infarction

AFib

9.5%

Unspecified atrial fibrillation

Pneumonia

6.6%

Pneumonia, unspecified organism

CHF

5.2%

Hypertensive heart disease w/ heart failure

Reporting Period: Index Admissions from 1/1/17 - 12/31/19

Data Source: MVC 30-day episodes from Medicare FFS, BCBSM PPO Commercial, BCN Commercial, BCBSM PPO MA, and BCN MA

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Blue Cross Blue Shield Blue Care Network of Michigan

Result of Post-Discharge ED Utilization

Proportion of Total ED Visits

60%
50%
40%
30%
20%
10%
0%

55%
45%

Readmitted
Went Home

Reporting Period: Index Admissions from 1/1/17 - 12/31/19

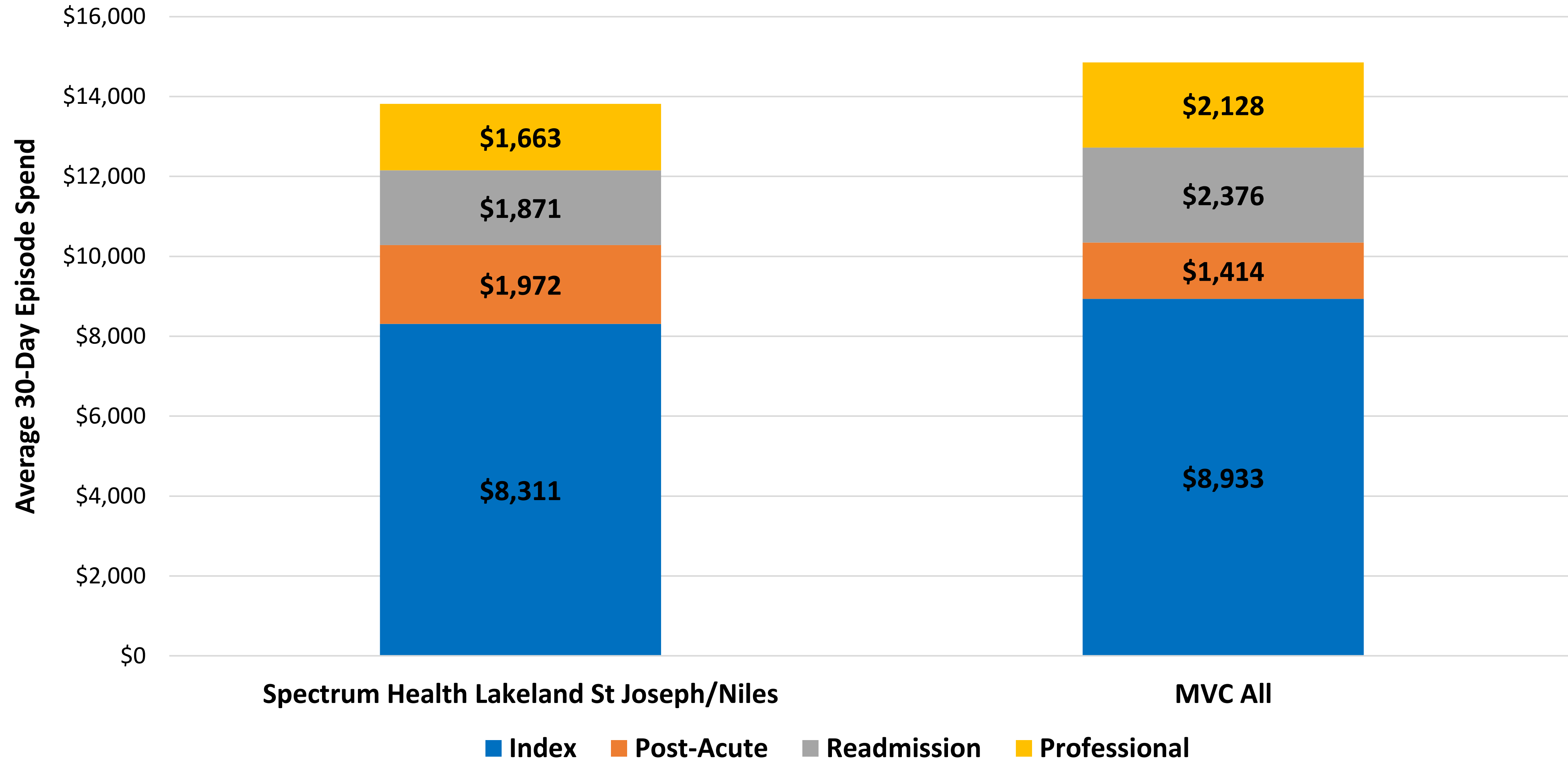
Data Source: MVC 30-day episodes from Medicare FFS, BCBSM PPO Commercial, BCN Commercial, BCBSM PPO MA, and BCN MA

Care connection efforts in the Emergency Department and impacts on admission rates and cost of care

Dr. Robert Nolan, DO, CMIO, Medical Director of Quality
Michael Getty, MBA, Sr. Director Analytics & Reg Compliance

MAY 2021

30-Day COPD Episode Spending Breakdown



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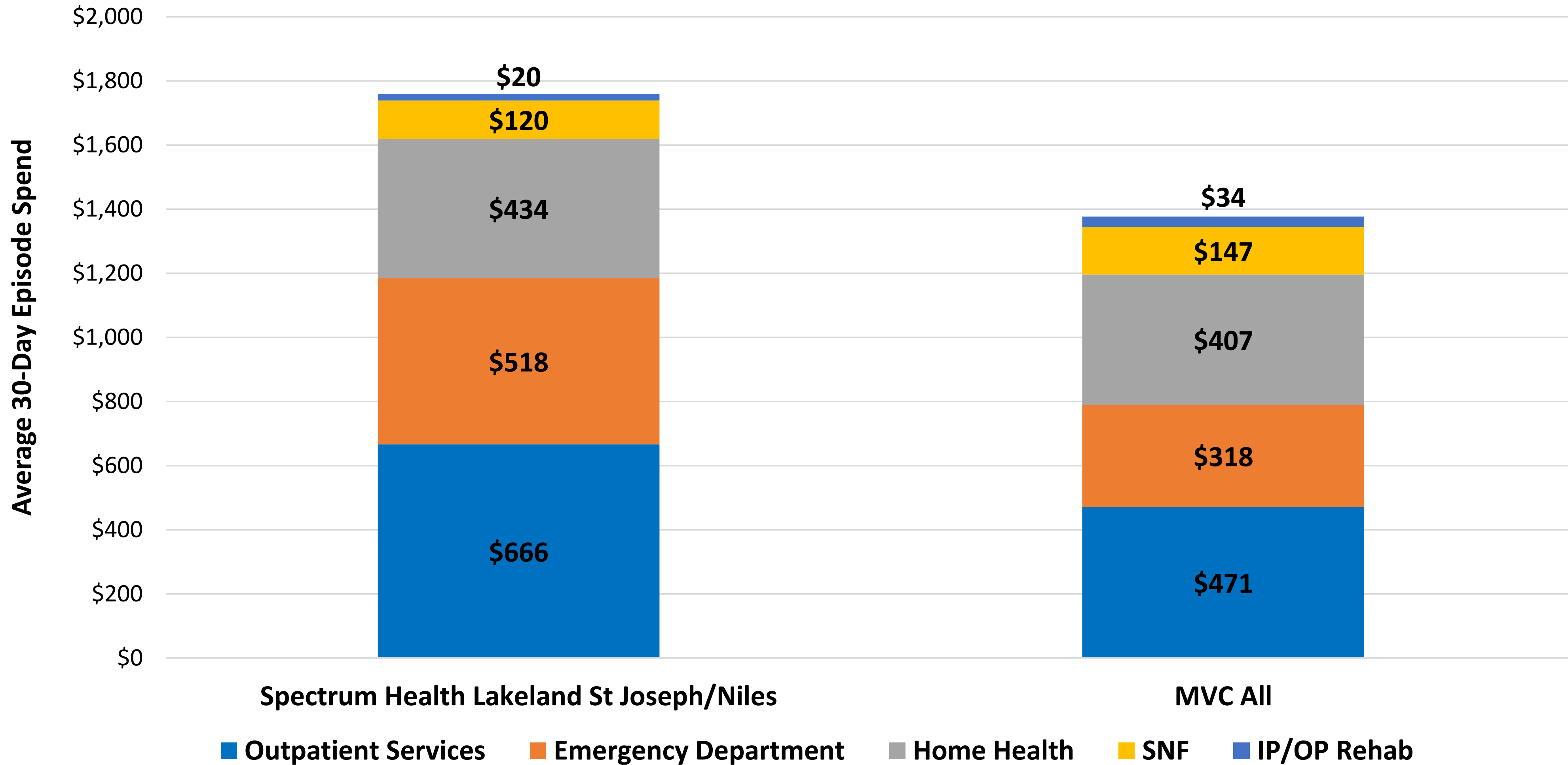
Spectrum Health Lakeland

30-Day Post-Acute Care Spending Breakdown After COPD



Spectrum Health Lakeland

Easy identification on the track board + LEDO integration into care tools

Real time data visuals & integrating documentation tools with best practices

ED Track Board (SJED)

Refresh | Review Visit | My Note | Orders | AVS | Sign Out | Tx Team | Comments | Tracking

All Patients (39) | My Patients (2) | Potential Admit (1) | ED Observation Unit (1) | Tent/Surge Patients (5) | Active ED Patients

Room	Patient	Age	Complaint	ED Recent Visit	30Day Readmit	TT
ED 05		76 YO	Hematochezia			15:19
ED 06		56 YO	Psychiatric Evaluation			14:17
ED 08		71 YO	Altered Mental Status			13:38
ED 09		13 YO	Suicidal Ideation			17:29
ED 10		70 YO	Ground Level Fall; Di...			15:12
ED 15		50 YO	Chest Pain; Difficulty...			13:12
ED 18		53 YO	Ground Level Fall; Ar...			18:18
ED 19		70 YO	Toe Pain			15:00
ED 20		67 YO				13:02
ED 21		55 YO	Foot Pain			20:04
ED 23		68 YO	Altered Mental Status			21:11
ED 24		71 YO	Headache; Difficulty...			17:02
ED 25/26		74 YO	Cough; Weakness			14:11
ED 27/28		69 YO	Difficulty Breathing			16:49
ED OBS 09		52 YO	Headache			40:18
ED OBS 11	(F)	40 YO	Dizziness; Difficulty B...			13:15
ER ENDO 01		22 YO	Other (cather problems)			14:49
ER ENDO 02		70 YO	Hematochezia			15:29

Triage | Workup | Reports | My Note | Orders | Dispo

Female,
CC: None

FYI
PCP: KLANSECK, RY

Mark All as Viewed

Drug/Medication Contract in place

This patient is followed by Lakeland's Emergency Department Overuse (LEDO) Committee — Chart Review -> Notes

BPA

Labs

ECG

ECG 12 lead--2hr
Completed 03/09/21 1234
ECG 12 lead--Initial
Completed 03/09/21 0916
ECG 12 lead--2hr

Vitals NEW — Historical Data

	BP	Temp	Heart Rate from Pulse Ox	Pulse	Resp	SpO2
0808	122/...	99 °F (37.2 °C)	—	88	22	—

Medication Status

RN Documentation

Spectrum Health Lakeland

An effective longitudinal plan of care for these patients is only feasible for an ED physician if it is blended into the natural work flows

Chart Review

Notes | Labs | Cardiology | ECG | Micro | Imaging | Encounters | Pathology | Procedures | Telemetry | Other Orders | Meds | Letters | Media | Misc Reports | LDAs | Dept Encounters - ROI

Preview | Refresh (8:09 AM) | Select All | Deselect All | Review Selected | Route | Tag | Load Remaining | Add to Bookmarks

Filters | Exclude | Me | Emergency Medicine | Lakeland Medical Cen... | Op Notes | HP | Provider | Discharge Summary | Progress Notes | Procedures | Consults | physician notes

Date of Service	Encounter Type	Type
03/18/2021 14:47	LEDO Committee En...	LEDO Note
03/18/2021 13:00	Home Visit - External...	Progress Notes
03/11/2021 09:45	Office Visit	Progress Notes
03/10/2021 10:24	Refill	Telephone Enc
03/10/2021 08:50	Refill	Telephone Enc
03/09/2021 12:29	ED	ED Procedure N
03/09/2021 09:13	ED	ED Procedure N
03/09/2021 08:43	ED	ED Provider No
03/09/2021 08:13	ED	ED Triage Note
03/06/2021 03:47	ED	ED Procedure N
03/06/2021 03:35	ED	ED Procedure N
03/06/2021 02:38	ED	Patient Instructi
03/06/2021 02:05	ED	ED Procedure N
03/06/2021 01:30	ED	ED Procedure N
03/06/2021 01:18	ED	ED Provider No
03/06/2021 01:05	ED	ED Notes
03/06/2021 00:53	ED	ED Triage Note
02/26/2021 01:34	ED	ED Procedure N
02/25/2021 23:38	ED	ED Provider No

Shelly Baldwin, RN — Case Manager — Specialty: Care Manager
LEDO Note — Signed
Encounter Date: 3/18/2021

LEDO Note

3/18/21

Treatment Recommendations:

ED recs:
-Admit as needed for missed dialysis and fluid overload/hyperK
-follows with palliative, please review Palliatives notes, and ask patient if she has contacted palliative if she is presenting for pain; feel free to contact them if concerning questions
-avoid prescribing chronic pain meds, pain meds per palliative
-Needs to see care management and motivational interviewing

Inpatient recs:

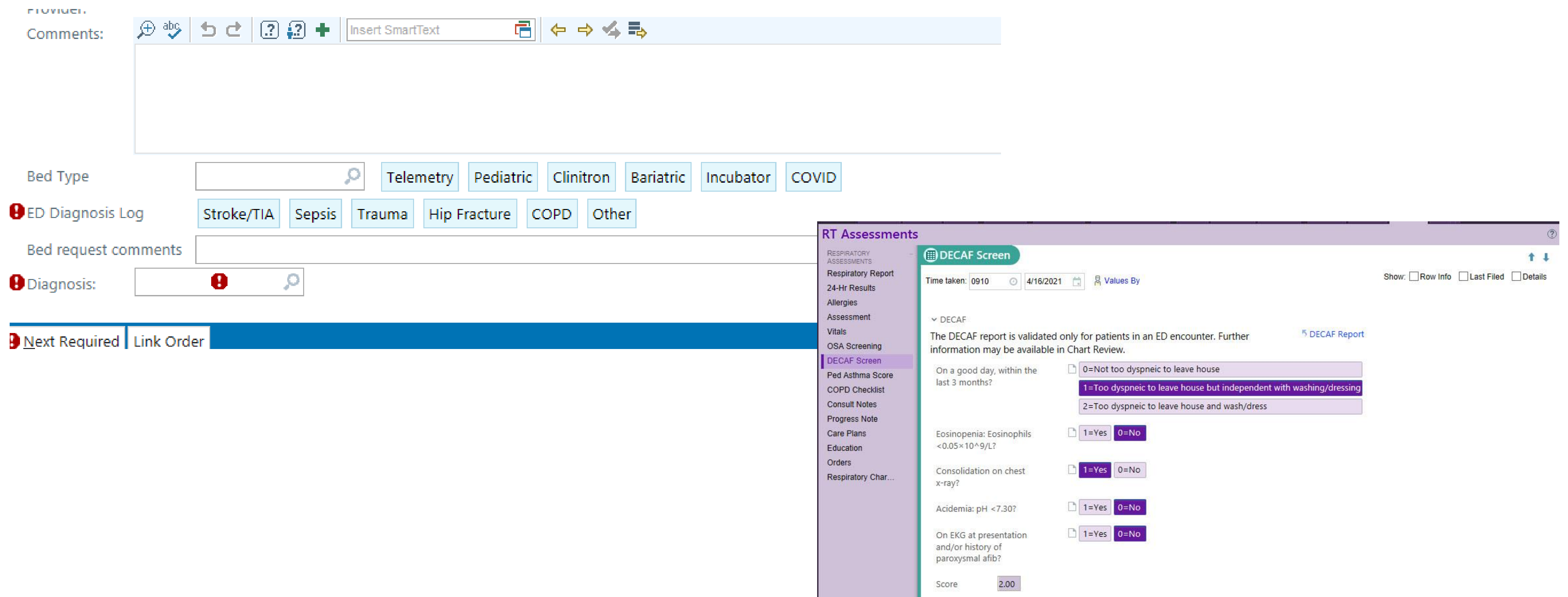
Care management plan:
-Assist patient with establishing with a PCP. Last palliative note states pt referred to Dr Klanseck but pt stated she would like to look for a provider herself.
-Receives Hemodialysis at Fresenius in Benton Harbor, Tues, Thurs, Sat.

Usual Presentations:
-Chronic pain (ab pain, chest pain), diarrhea/nausea/vomiting, anxiety and depression, fluid overload
-usually very hypertensive and tachycardic into the 120s
-LFTs increasing

Spectrum Health Lakeland

ED physicians can flag patients for quality evaluation cohorting

Great success with DECAF scoring for optimal levels of care and treatment plans



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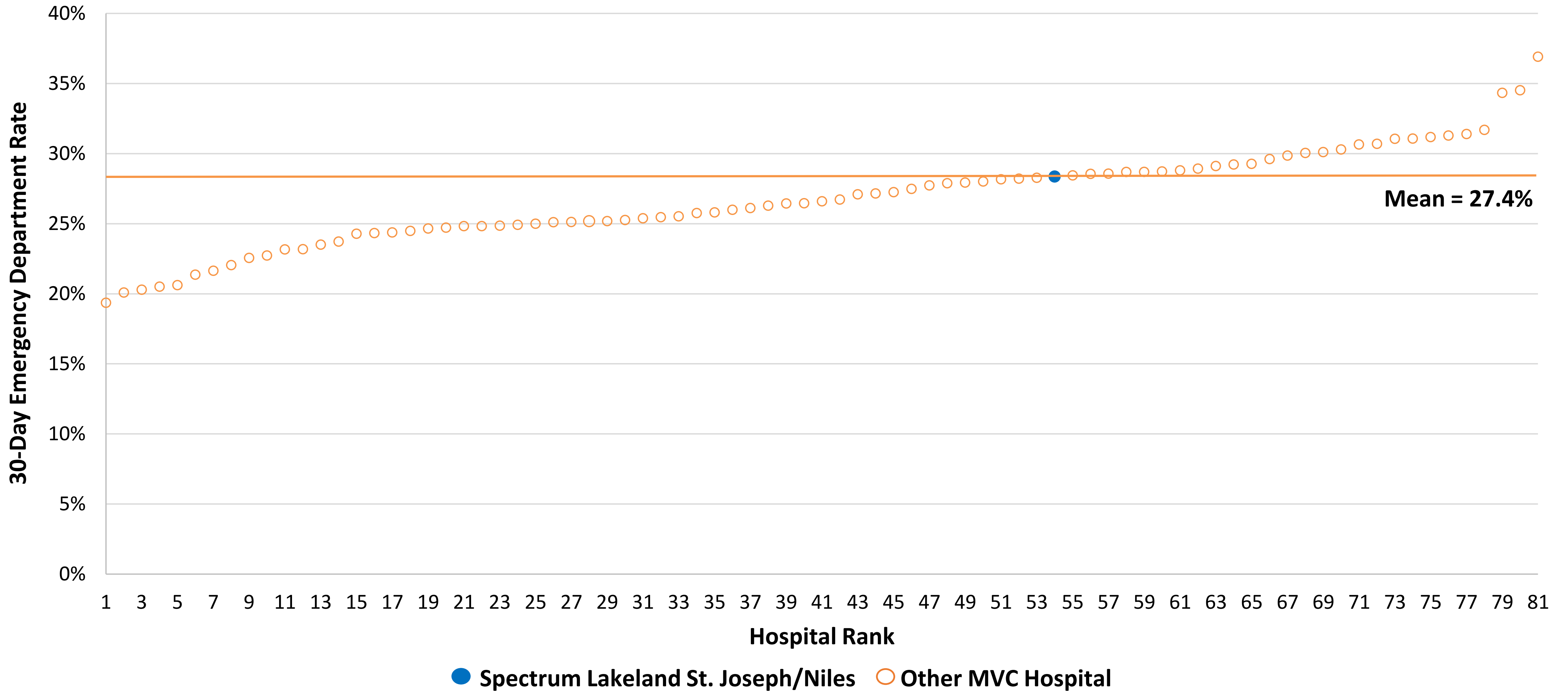
30-Day COPD Emergency Department Rates and Readmission Rates



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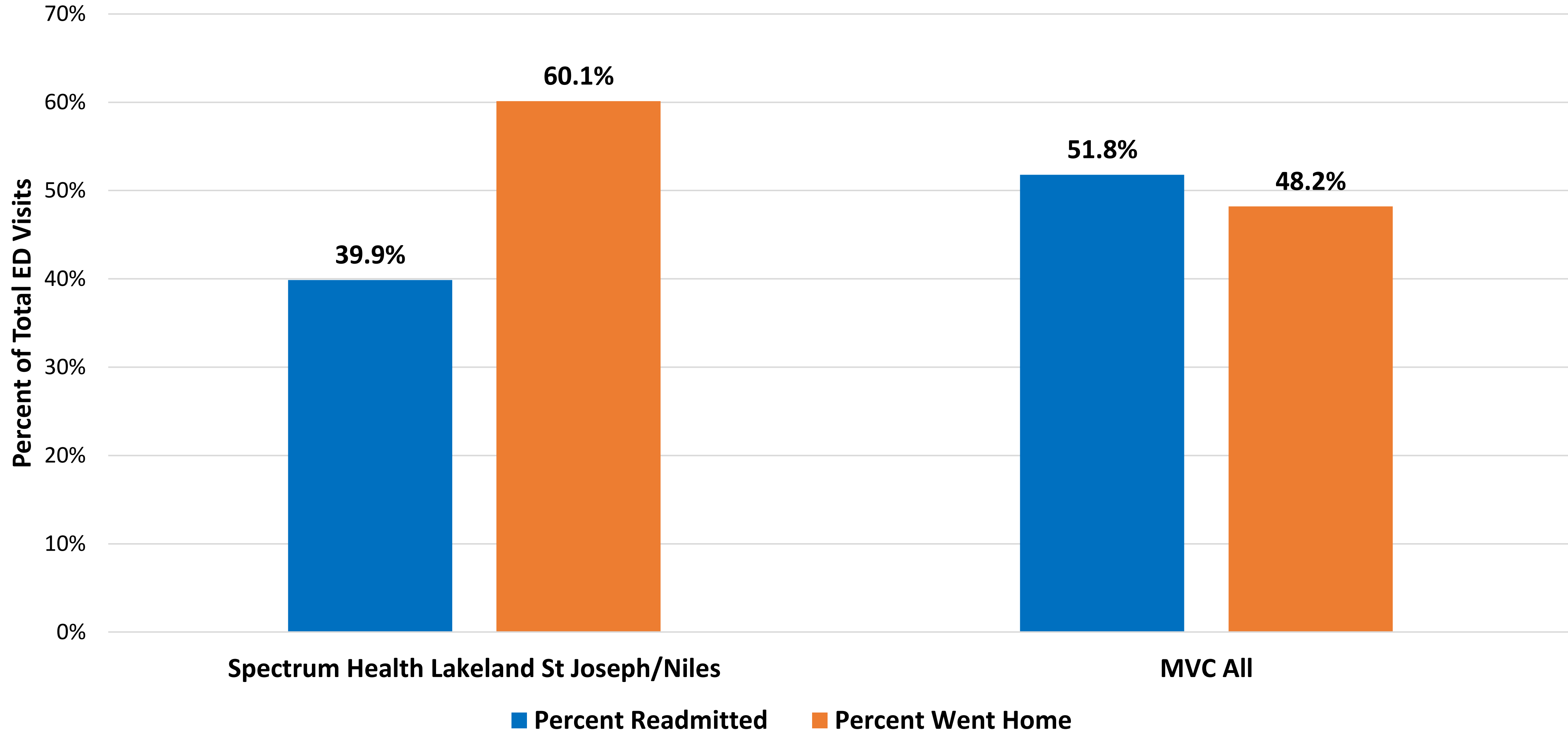
30-Day Emergency Department Visits that Resulted in a Readmission Compared to those who went Home (COPD)



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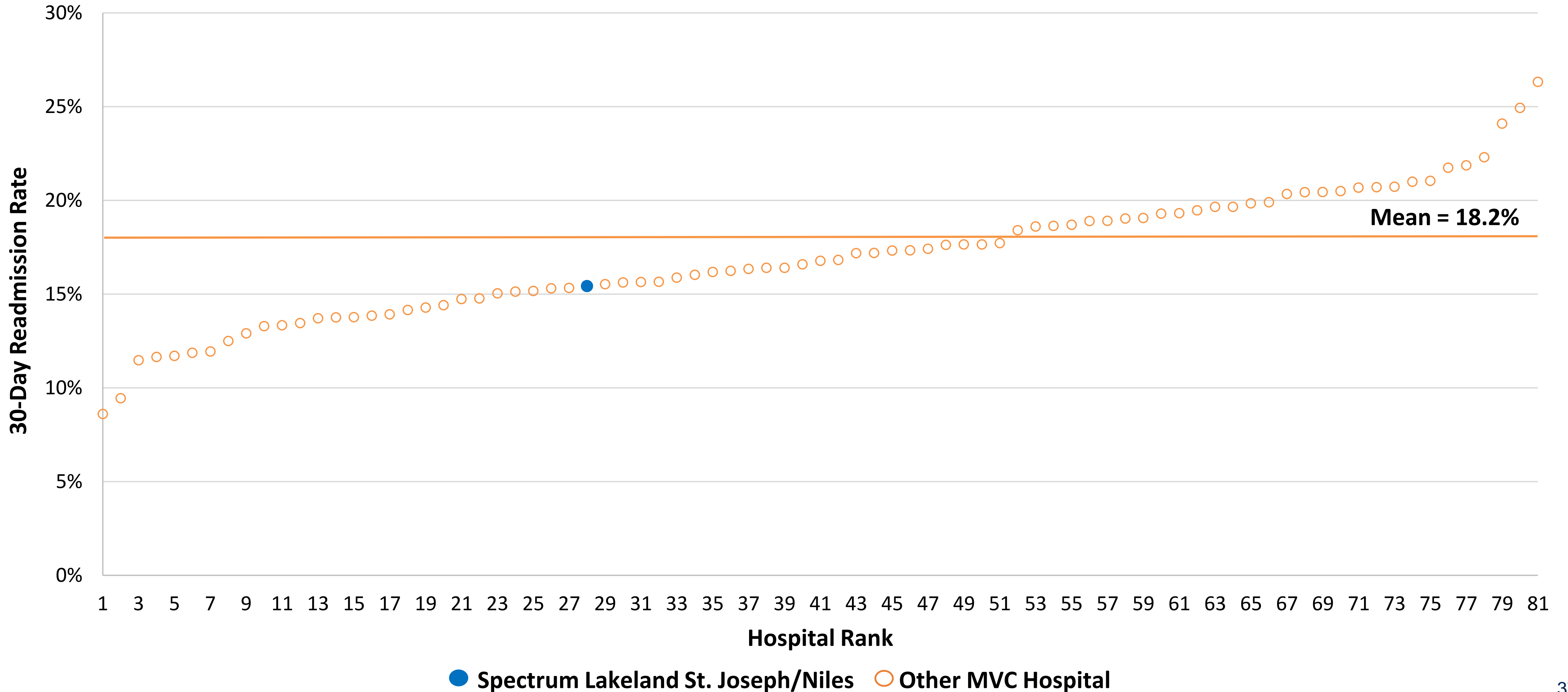
30-Day COPD Readmission Rates



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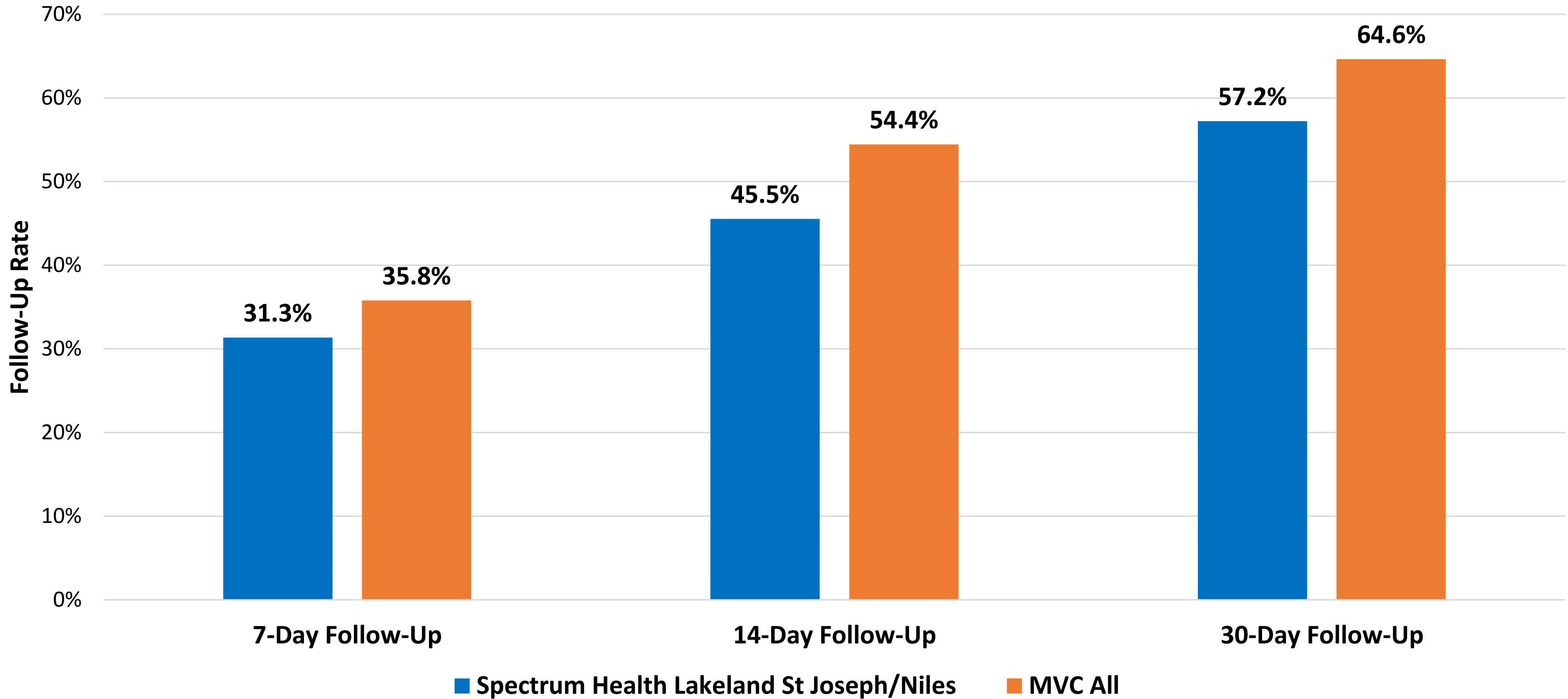
SHL opportunities: Follow-Up Rates After COPD



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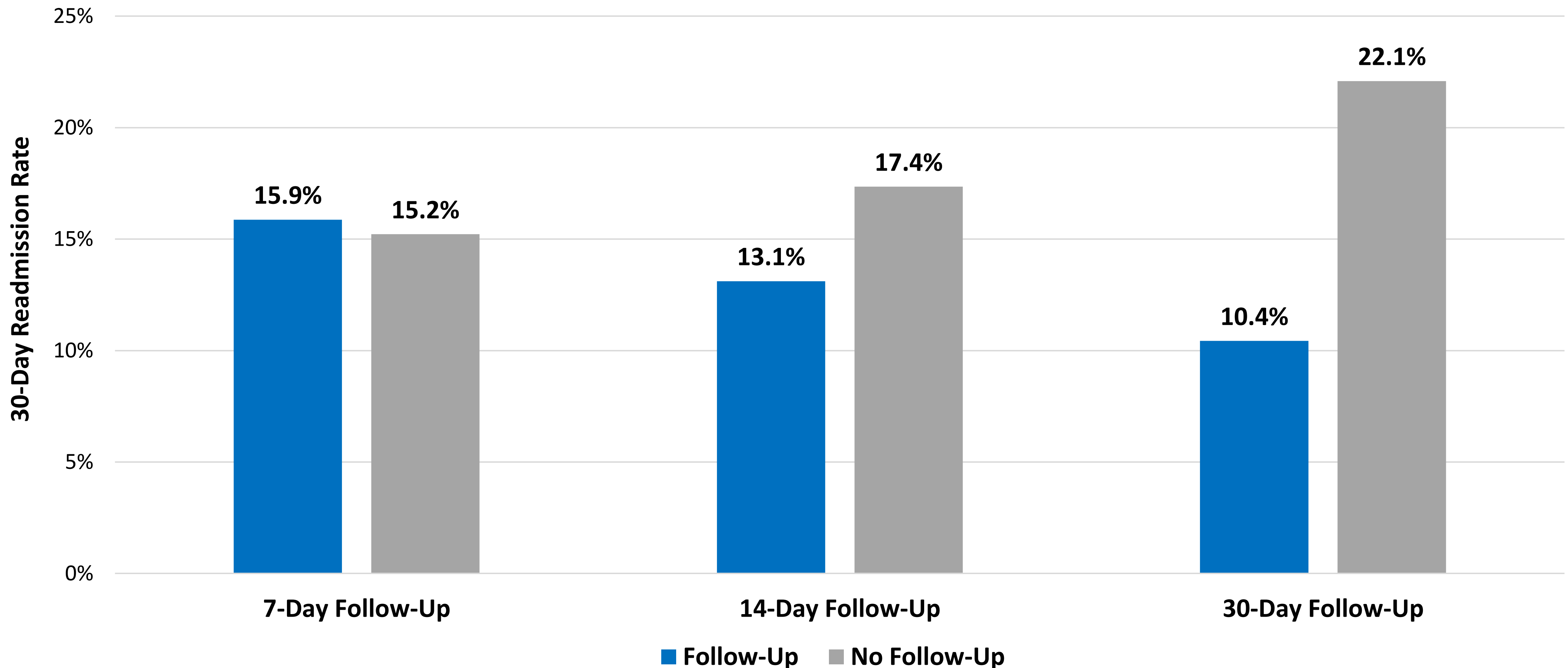
SHL opportunities: 30-Day Readmission Rates by Follow-Up Window at Spectrum Health Lakeland St. Joseph/Niles (COPD)



Spectrum Health
Lakeland

Thank you

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Special thank you to:

Chelsea Abshire, John Syrjamaki, Deby Evans, and Mark Bradshaw at MVC for both great collaboration and many data/visualizations you find throughout the presentation.

How CIPA and PMC help PCPs promote appropriate emergency care

Kyle S. Enger, MPH, PhD
Senior Analytics Consultant
Professional Medical Corporation (PMC); Consortium of Independent Physician Associations (CIPA)

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Emergency departments are often overused

- Many reasons for this:
  - Poorly managed medical conditions; Primary Care Sensitive (PCS) conditions
    - Patients lack medical homes
    - Lack of insurance or concerns about coverage (up-front costs to patients)
  - Unfamiliar with local urgent cares or when to use them
    - Urgent cares may not exist, especially in rural areas
    - Extended hours by PCPs can mitigate this; consultants promote extended hours using ED visit data
  - Everyone knows the local hospital! (habit, convenient, accessible)
    - ED is always open; but PCPs or urgent cares may lack extended hours
    - Transportation issues (bus stops at ED, not at urgent/primary care)
    - Pattern of repeated crises; patient knows what to expect at ED
- If not an emergency, urgent/primary care is usually better and less costly
- Reducing ED crowding helps patients who need emergency care
- However, must not discourage genuine emergencies from visiting ED

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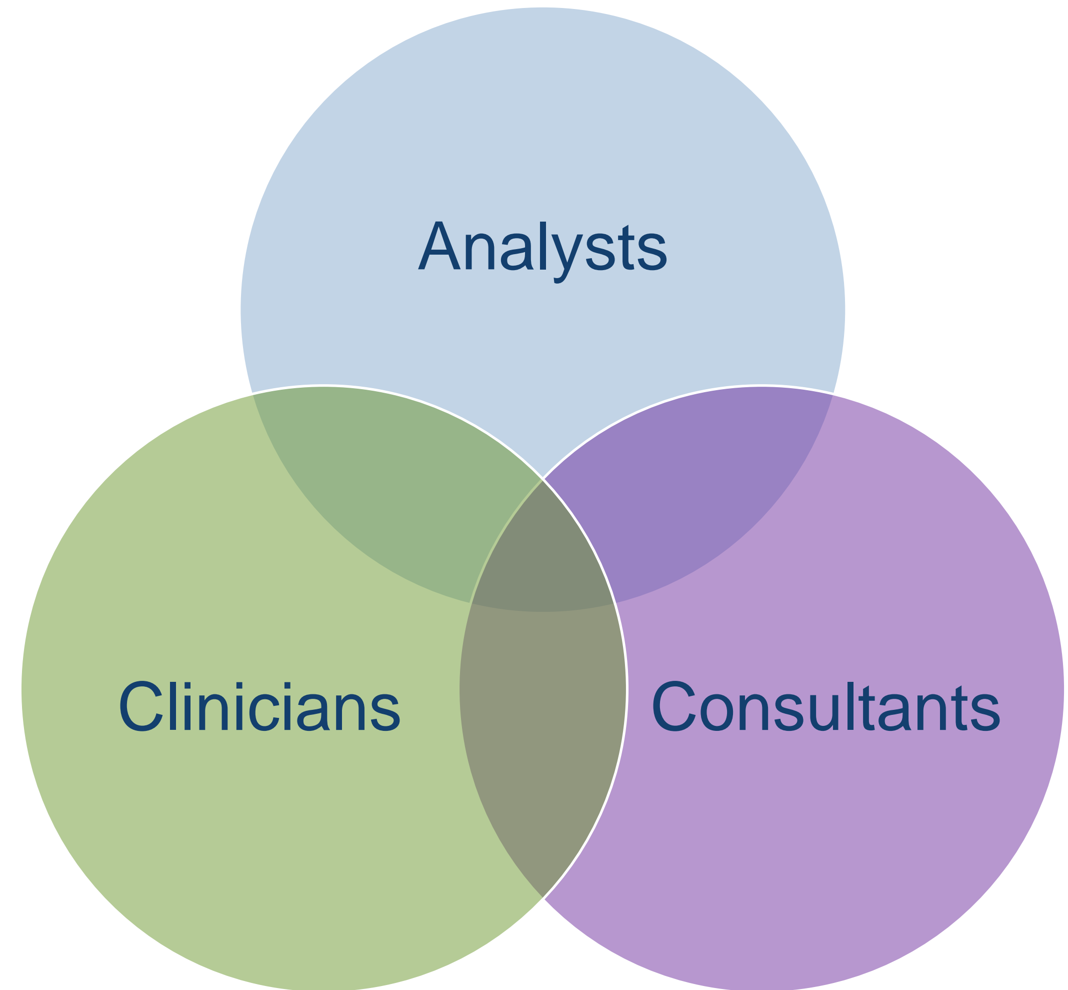
Reports guide PO consulting and primary care

- Reports show opportunities to improve for consultants and providers
- Consultants:
  - use reports to guide their work
  - provide and interpret them for (busy) providers
- Feedback from providers and consultants helps analysts improve reports
- Plan→Do→Study→Act (PDSA) cycles



Monthly 'report cards': excerpt

Quality, cost, and utilization from claims, compared to PO						
Metric	Current period ‡	Previous period ‡	% change	Current period PO	Benchmark *	Your practice's rank
Primary Care Focused Quality						
Days from serv. to paid, PCP claims	17.64	19.50	↓↓ -9.6%	**22.49**	N/A	16
% complete AWV	25.8%	25.0%	↑ 3.2%	25.8%	**70.0%**	19
Mean aged/non-dual risk score, YTD (	0.53	0.54	↓ -3.1%	0.54	N/A	21
Mean aged/non-dual risk score, 12m (	0.98	0.95	↑ 2.4%	**0.86**	N/A	13
% patients w. PCP visit in 6m	76.1%	56.7%	↑↑ 34.2%	77.4%	**90.0%**	17
% patients ACP visit in 12m	0.0%	0.0%		**7.1%**	N/A	32
% ED w. follow-up by 14d	72.2%	71.4%	↑ 1.1%	69.0%	75.0%	16
% IP w. follow-up by 14d	70.0%	42.9%	↑↑ 63.3%	**61.6%**	75.0%	10
% ED or IP, less serious dx	14.3%	20.7%	↓↓ -30.9%	**19.8%**	**20.0%**	17

- Metrics calculated from claims; trended; 'average' and 'challenging' benchmarks
- Ranking practices is motivational; we also name top performers
- Reports shared with providers directly via web portal (consultants help with this)

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Using the ‘report cards’

- Consultants review them with providers
- Physician leadership and consultants compare metrics among practices; offer assistance where needed
- Provider recognition
- Some metrics are used in ACO payment model; higher performance means more gainsharing

Amanda Winston, MD
Best ED/IP follow-up (93%)
PMC ACO, 2020

Josephine Bello, MD
Most improved ED/IP follow-up
19 percentage point increase in 12m
PMC ACO, 2020

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Hospital information

Facility name	Utilizing members	# encs.	% with obser.	Days / utilizer	Cost per day	Cost per utilizer	Cost Total	30-day readmits† Percent Any	30-day readmits† Percent IP-IP	30-day readmits† Number ED	30-day readmits† Number ED&IP	30-day readmits† Number IP	30-day readmits† Number SNF
ED; cost per assigned member is $757.37													
All facilities	41	71	14.1%	2.17	$1,702	$3,694	$151,473	32%	NA	15	4	4	NA
FACILITY 1	31	56	12.5%	2.23	$1,620	$3,607	$111,808	34%	NA	13	4	2	NA
Facilities with only 1 patient	3	4	0.0%	1.33	$3,205	$4,273	$12,820	25%	NA	1	0	0	NA
FACILITY 2	3	3	66.7%	2.33	$1,684	$3,929	$11,788	33%	NA	0	0	1	NA
FACILITY 3	4	5	0.0%	1.50	$1,708	$2,562	$10,247	20%	NA	1	0	0	NA
Unknown	3	3	33.3%	1.00	$1,603	$1,603	$4,810	33%	NA	0	0	1	NA
ED&IP; cost per assigned member is $1708.40													
All facilities	14	17	0.0%	7.64	$3,193	$24,406	$341,681	12%	0%	2	0	0	NA
FACILITY 1	7	8	0.0%	7.00	$4,625	$32,375	$226,627	13%	0%	1	0	0	NA
Unknown	3	4	0.0%	11.67	$1,810	$21,117	$63,350	25%	0%	1	0	0	NA
FACILITY 2	2	2	0.0%	4.50	$2,377	$10,698	$21,395	0%	0%	0	0	0	NA
FACILITY 4	2	2	0.0%	5.50	$1,902	$10,464	$20,927	0%	0%	0	0	0	NA
Facilities with only 1 patient	1	1	0.0%	3.00	$3,127	$9,381	$9,381	0%	0%	0	0	0	NA
IP; cost per assigned member is $1266.99													
All facilities	9	9	0.0%	6.00	$4,693	$28,155	$253,397	11%	0%	1	0	0	NA

- PCP practices can see the facilities their patients use, plus util. & cost info
- 2 types of readmits: 1) ED or IP followed by another ED or IP; 2) IP followed by IP
- The report also shows the same info for home health and SNF facilities

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Admissions/discharge/transfer (ADT) messages

- Facilitate coordination of care and timely follow-up after ED or IP visits
- Not all visits generate an ADT; but some is better than none
- Ideally PCP and specialist practices receive & respond to ADTs via their EMR
  - Multiple EMRs and lack of EMR knowledge make this difficult
- CIPA and PMC clinicians can access ADTs through Carespective web portal
  - Updated daily; nurses and care managers use them more than physicians
  - Use ADTs to follow up with patients and educate on ED vs. urgent care vs. after-hours
- PMC ACO monitors an ADT service daily
  - Sends real-time text message notifications to doctors for ED & IP admissions
  - Schedules PCP follow-up appointments

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ADT messages in Carespective web portal

Physician ADTs

Since: 04/[redacted]/2021 08:27 AM

Show 10 entries

Search:

	Last Name	First Name	Latest Status	Status Date	Facility	Patient Class	Admitted From/Discharged To	Status
+	[redacted]	[redacted]	Register a Patient	04/[redacted]/2021 [redacted] am	[redacted]	Recurring Patient	Clinic Referral	Admit - Elective
−			Discharge / End Visit	04/[redacted]/2021 [redacted] am		Emergency	Home	Discharge - Home or Self Care

View Patient Info | View ADT History | View Diagnosis History

Show 10 entries

Search:

Date	Status	Facility	Patient Class	Admitted From/Discharged To	Status
04/[redacted]/2021 [redacted] am	Discharge / End Visit	[redacted]	Emergency	Home	Discharge - Home or Self Care
04/[redacted]/2021 [redacted] am	Admit/Visit Notification	[redacted]	Emergency	Info Not Available	Admit - Emergency
04/[redacted]/2021 [redacted] am	Register a Patient	[redacted]	Emergency	Info Not Available	Admit - Emergency
04/[redacted]/2021 [redacted] am	Register a Patient	[redacted]	Emergency	Info Not Available	Admit - O *

Showing 1 to 4 of 4 entries

Previous 1 Next

	Last Name	First Name	Latest Status	Status Date	Facility	Patient Class	Admitted From/Discharged To	Status
+	[redacted]	[redacted]	Discharge / End Visit	04/[redacted]/2021 [redacted] pm	[redacted]	Emergency	Home	Discharge - Home or Self Care
+			Change Outpatient to Inpatient	04/[redacted]/2021 [redacted] pm		Inpatient	Admission	Admit - Emergency
+			Register a Patient	04/[redacted]/2021 [redacted] pm		Recurring Patient	Clinic Referral	Admit - Elective
+			Discharge / End Visit	04/[redacted]/2021 [redacted] pm		Inpatient	Home	Discharge - Home or Self Care

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Promoting urgent care

- Urgent care advantages:
  - Many locations (possibly the patient's PCP)
  - Shorter wait times than ED
  - Lower cost
- Information for patients
  - Consultants share handouts with providers
  - Providers share them with patients
  - Many public examples (e.g., from Greater Detroit Area Health Council)
  - Calls/letters to patients after ED/IP discharge
  - Lists of local urgent cares
    - Promote good ones; exclude bad ones
    - Refrigerator magnets for patients
    - Phone numbers and evening/weekend hours
- Reporting on urgent care is difficult because it's not clearly defined on health care claims

I'm sick or hurt...
Where do I go?
(Or, where do I take my child or parent?)

Brought to you by the Greater Detroit Area Health Council, © 2013
www.gdahc.org / A non-profit health care coalition

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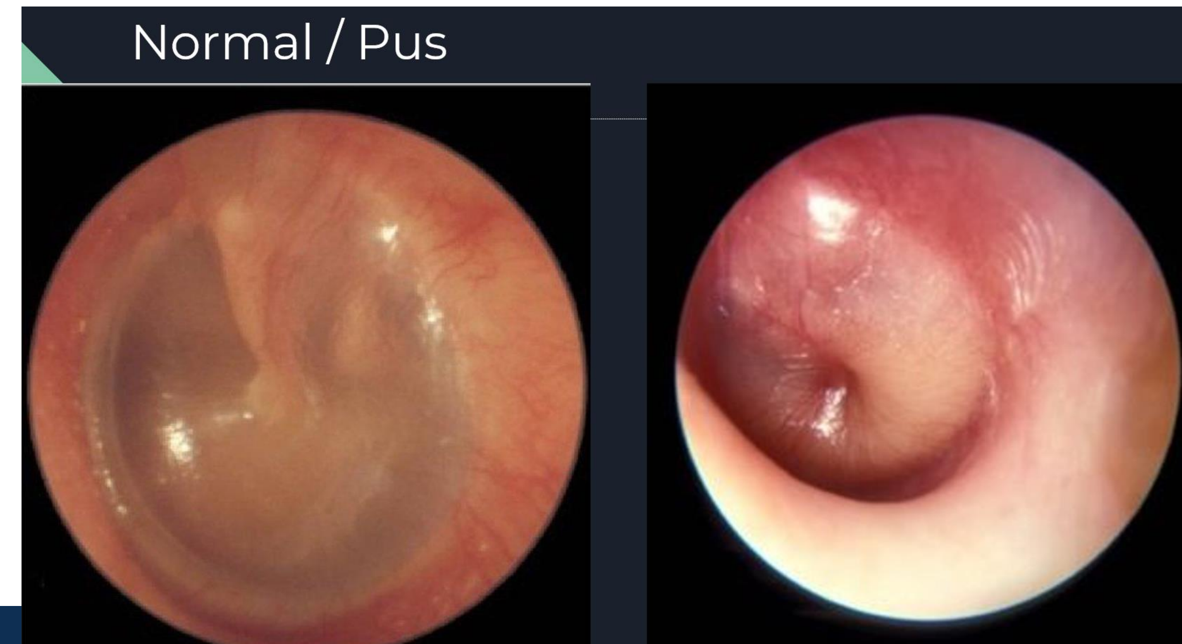
Relationships: Physicians, consultants, urgent cares

- Consultants are liaisons between PCPs, specialists, and urgent cares
  - Hear comments from multiple PCPs about particular urgent cares
  - Consultants relay suggestions for better care to urgent cares
  - Consultants share lists of PO PCPs with urgent cares to facilitate communication
- Physician outreach to urgent cares: Bobby Mukkamala, MD; ENT (Mar. 2021)
  - Patients see urgent care with ear complaint and then visit ENT
    - Urgent care: fluid or bulging eardrum; antibiotics
    - But eardrum looks normal in ENT practice
  - Videocall education with 6 urgent cares
    - Encourage proper diagnosis
    - Encourage judicious antibiotic use
- Which urgent cares to avoid (rare)
  - Overutilize or overcharge
  - Resist sharing info with PCPs



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Readmissions from the Emergency Department:

Insights from the Michigan Emergency Department Improvement Collaborative

Keith Kocher, MD MPH

MEDIC Director

Department of Emergency Medicine

University of Michigan

MVC Collaborative-Wide Meeting | 5.7.21

Disclosures

- Michigan Emergency Department Improvement Collaborative (MEDIC)
  - www.medicqi.org (Kocher, PI)
  - Blue Cross Blue Shield of Michigan and Blue Care Network

- Multicenter Study of the Emergency Department Trigger Tool
  - R01 HS027811 (Griffey, PI)
  - Agency for Healthcare Research and Quality (AHRQ)

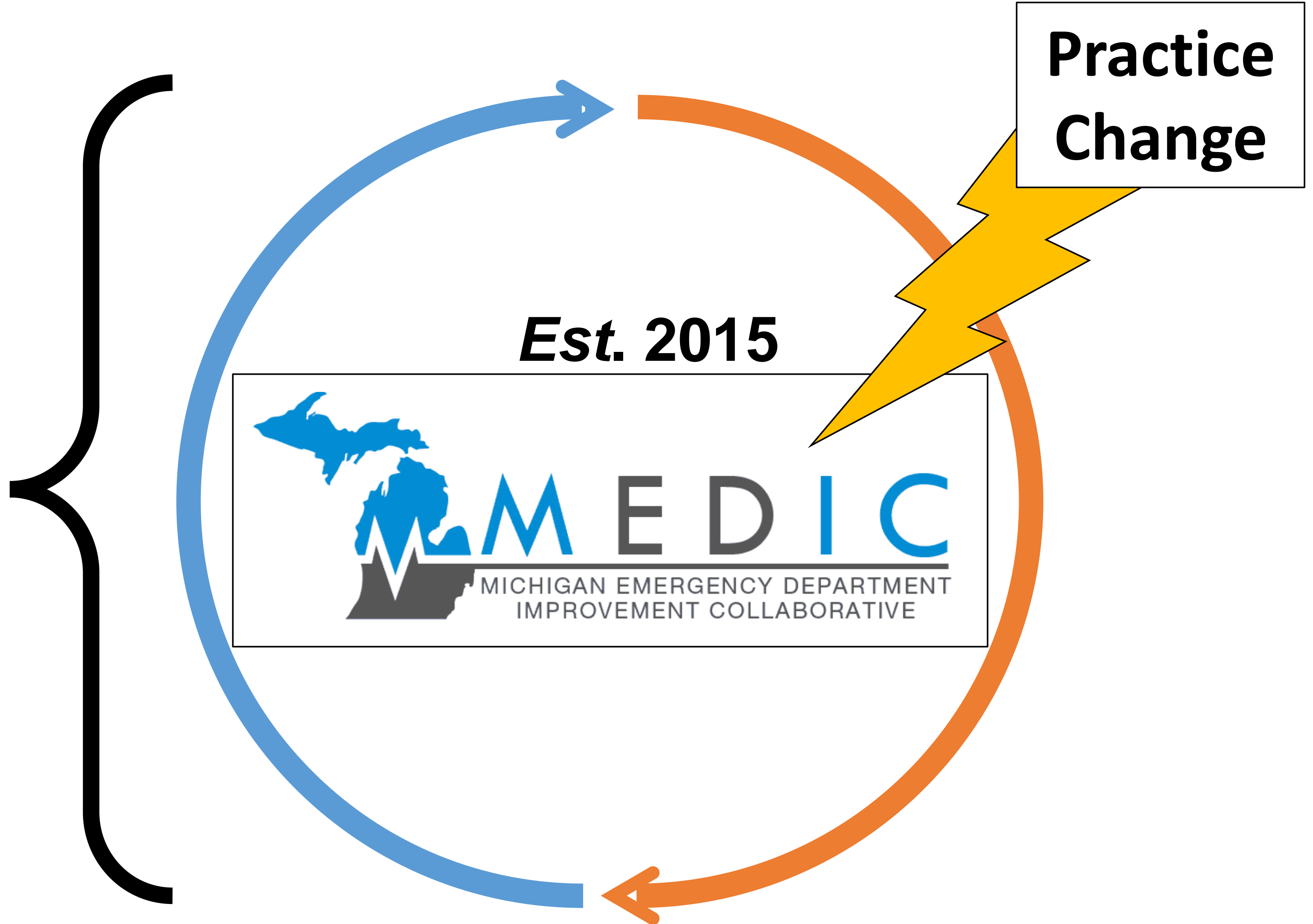
- Opioid Harm Reduction and Treatment Quality in Acute Care
  - State Opioid Response II Grant (Brummett, Waljee, Englesbe, Kocher, Co-PIs)
  - Substance Abuse and Mental Health Services Administration (SAHMSA)/Michigan Department of Health and Human Services (MDHHS)

Overview

- MEDIC overview and scope – 1 minute
- Orientation to the emergency department – 2 minutes
- Readmissions from the emergency department – 5 minutes
- Questions & answers

What is MEDIC?

Learning Collaborative



OUR PARTNERS

37 participating sites & growing

Spectrum Health

Beaumont

DMC
DETROIT MEDICAL CENTER

MUNSON HEALTHCARE

MERCY HEALTH
A Member of Trinity Health

ALL major pediatric EDs in MI

REGISTRY & QI

5+ million
ED visits in our data registry

400,000+
abstracted ED visits in our data registry

6 active quality improvement performance initiatives

CT for Adults w/ Minor Head Injury

CXR for Children w/ Respiratory Illness

Safe Discharge for Children w/ Asthma

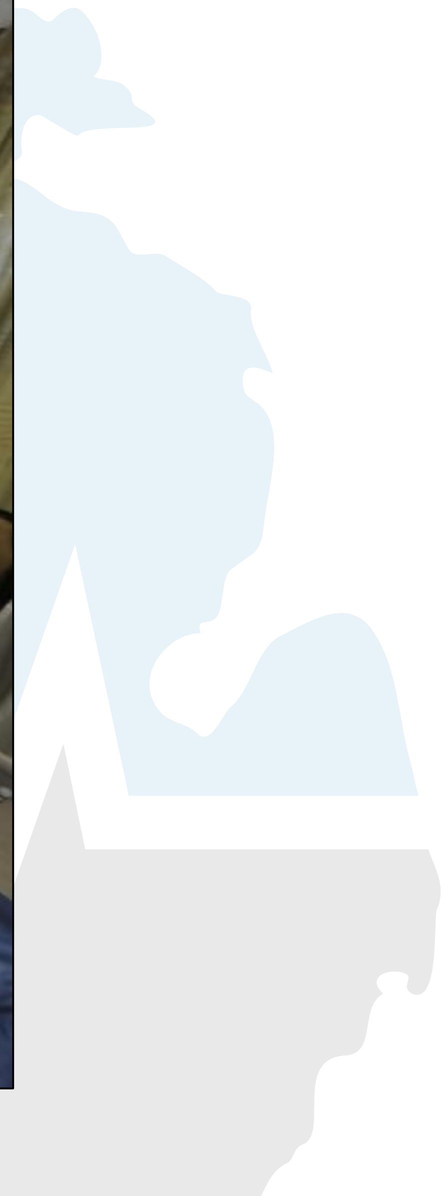
CT for Children w/ Minor Head Injury

CT for Adults w/ Suspected PE

Safe Discharge for Adults w/ Low Risk Chest Pain

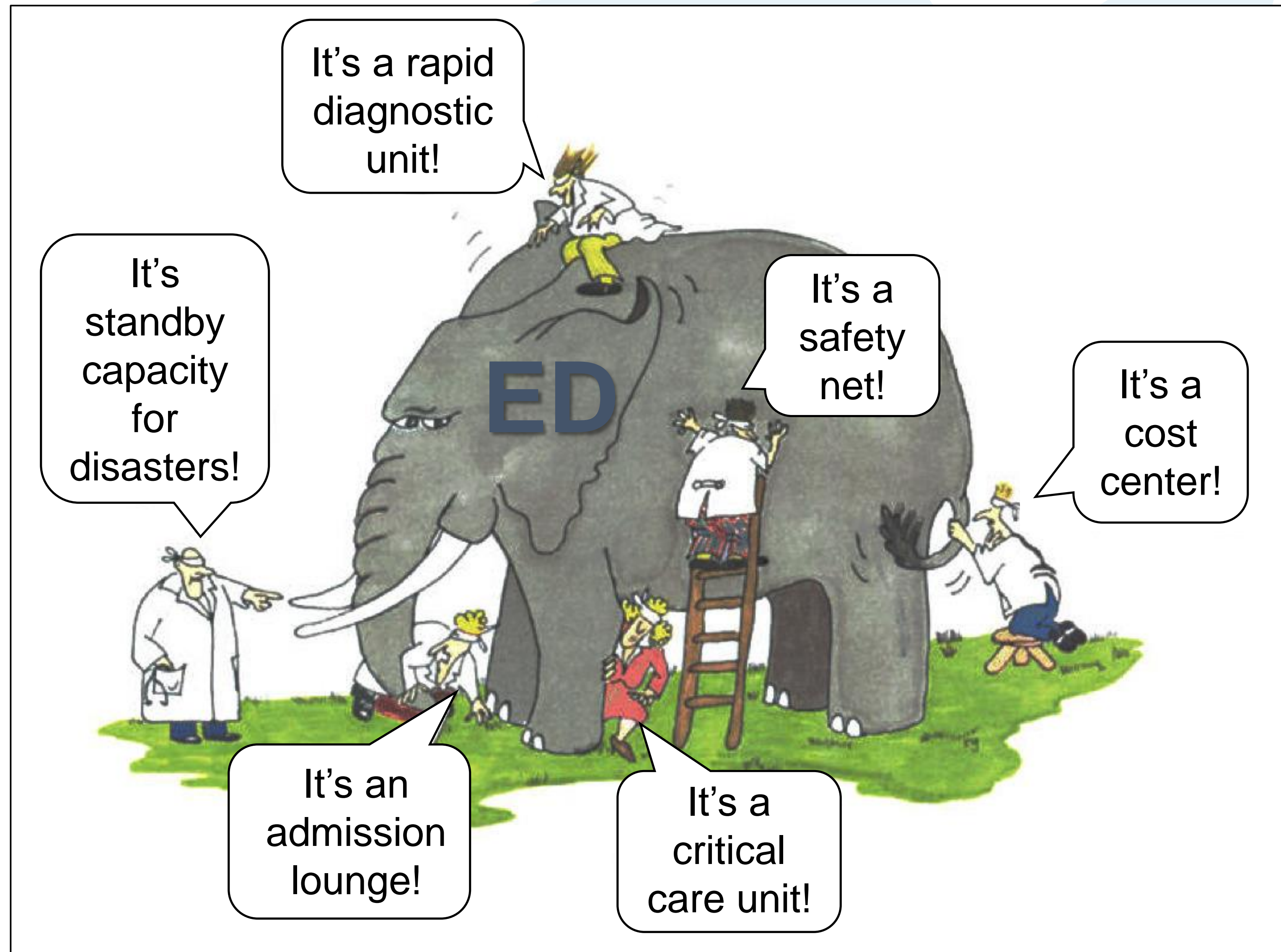
Orientation to the Emergency Department

Orientation to the Emergency Department



Orientation to the Emergency Department

Orientation to the Emergency Department



Orientation: ED Vital Statistics

- There are about 139 million ED visits annually

  = A little less than 1 ED visit for every 2 people in the US

  National Hospital Ambulatory Medical Care Survey, CDC, 2017

- Aggregate spending on emergency care is probably 5% - 6% of total national health expenditures

  Lee MH, Schuur JD, Zink BJ, Owning the Cost of Emergency Medicine: Beyond 2%, *Annals of Emergency Medicine*, 2013

Orientation: ED Vital Statistics

- More than half of all hospital admissions are sourced from the ED

  = About 18 million annually

  Schuur JD, Venkatesh AK, The Growing Role of Emergency Departments in Hospital Admissions, *New England Journal of Medicine*, 2012

- On average, about 17% of all ED visits result in hospitalization, but for those age >65 its about 40%

  Pallin DJ, Allen MB, Espinola JA, Camargo CA, Jr, Bohan JS, Population Aging and Emergency Departments: Visits Will Not Increase, Lengths-of-Stay and Hospitalizations Will, *Health Affairs*, 2013

=

- Collectively, EDs in the US make the decision to hospitalize about *400,000 times a day* across *5,000 EDs*
- <u>*ED controls the most consequential routine decision in health care*</u>

Readmissions from the Emergency Department

EDs play a role!

Health Affairs
EMERGENCY CARE

By Keith E. Kocher, Brahmajee K. Nallamothu, John D. Birkmeyer, and Justin B. Dimick

Emergency Department Visits After Surgery Are Common For Medicare Patients, Suggesting Opportunities To Improve Care

shm Journal of HOSPITAL MEDICINE www.journalofhospitalmedicine.com

ORIGINAL RESEARCH

Variation in Readmission Rates by Emergency Departments and Emergency Department Providers Caring for Patients After Discharge

Siddhartha Singh, MD, MS[1,2*], Yu-Li Lin, MS[3], Ann B. Nattinger, MD, MPH[1,2], Yong-Fang Kuo, PhD[3], James S. Goodwin, MD[3]

[1]Center for Patient Care and Outcomes Research, Medical College of Wisconsin, Milwauke Department of Medicine, Medical College of Wisconsin, Milwaukee, Wisconsin; [3]Department Texas Medical Branch, Galveston, Texas.

Journal of Hospital Medicine
ORIGINAL RESEARCH

Association Between Postdischarge Emergency Department Visitation and Readmission Rates

Arjun K. Venkatesh, MD, MBA, MHS[1,2*], Changqin Wang, MD, MS[1], Yongfei Wang, MS[1], Faseeha Altaf, MPH[1], Susannah M. Bernheim, MD, MHS[1,3], Leora Horwitz MD, MHS[4,5,6]

THE ANNALS OF THORACIC SURGERY

Hospital-Based, Acute Care Use Amon Within 30 Days of Discharge After Coronary Artery Bypass Surgery

Justin P. Fox, MD, MHS, Lisa G. Suter, MD, Karen Wang, MD, MHS, Yongfei Wang, MS, Harlan M. Krumholz, MD, SM, and Joseph S. Ross, MD, MHS

Department of Surgery, Boonshoft School of Medicine, Wrigh Medicine, New Haven; Section of General Internal Medicine, V.A. Connecticut Healthcare System, West Haven; Center fo Haven; Robert Wood Johnson Foundation Clinical Scholars P Haven; Section of Cardiovascular Medicine, Yale School of M Yale School of Public Health, New Haven, Connecticut

THE JOURNAL OF ARTHROPLASTY

Temporal Trends and Predictors of Thirty Emergency Department Visits Following T Ontario Between 2003 and 2016

Tayler D. Ross, BSc [a], Erind Dvorani, MPH [b], Refik Saskin, MSc [b], Amir Khoshbin, MD, MSc, FRCSC [c], Amit Atrey, MD, MRCS, FRCS [c], Sarah E. Ward, MD, MLA, MSc, FRCSC [c, *]

[a] School of Medicine, Royal College of Surgeons in Ireland, Dublin, Ireland
[b] Institute for Clinical Evaluative Sciences, Toronto, Ontario, Canada
[c] Division of Orthopaedic Surgery, St. Michael's Hospital, University of Toronto, Toronto, Ontario, Canada

JAMA Network | Open

Original Investigation | Health Policy

Assessment of Hospital Readmissions From the Emergency Department After Implementation of Medicare's Hospital Readmissions Reduction Program

Charleen Hsuan, JD, PhD; Brendan G. Carr, MD, MA, MS; Renee Y. Hsia, MD, MSc; Geoffrey J. Hoffman, PhD, MPH

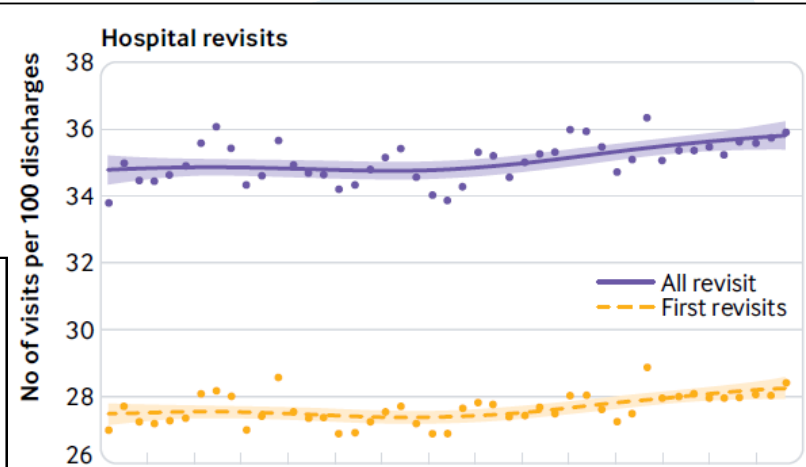
Readmissions from the Emergency Department

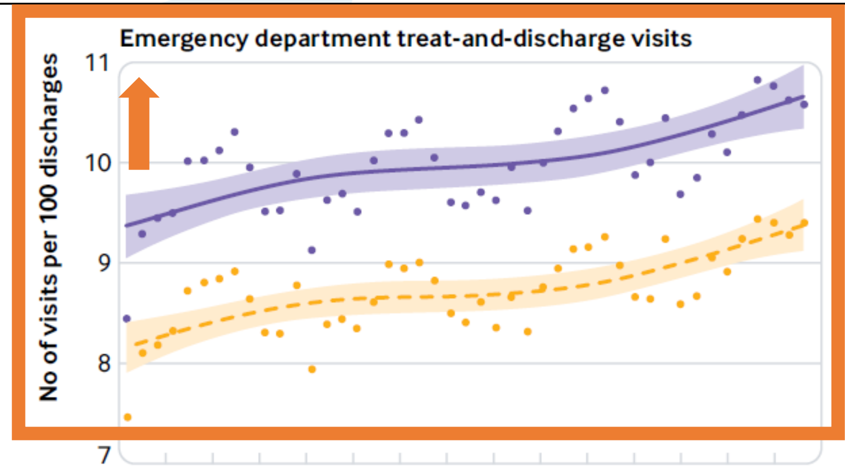
EDs play a role!

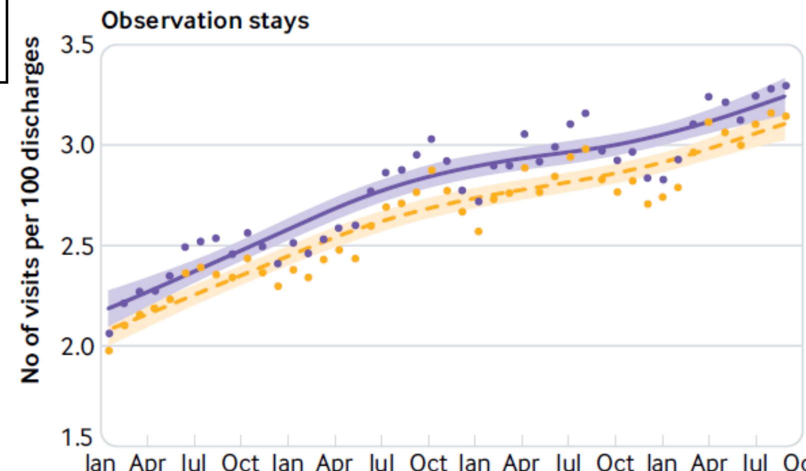
thebmj RESEARCH

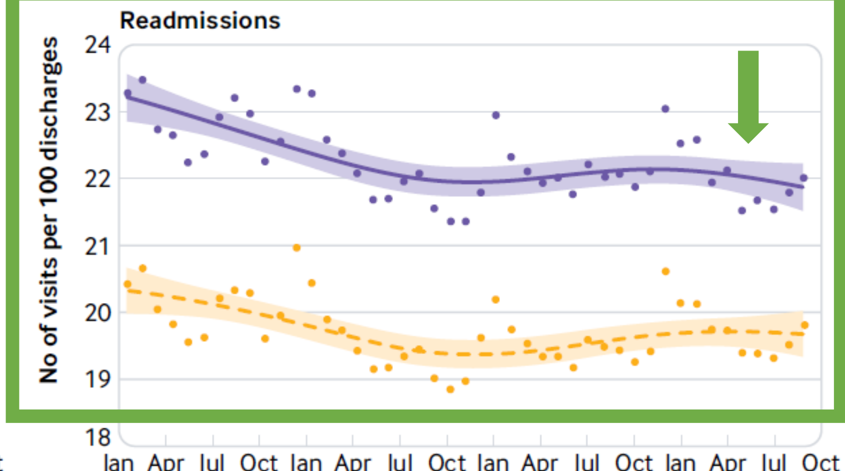
Hospital revisits within 30 days after discharge for medical conditions targeted by the Hospital Readmissions Reduction Program in the United States: national retrospective analysis

Rishi K Wadhera,[1] Karen E Joynt Maddox,[2] Dhruv S Kazi,[1] Changyu Shen,[1] Robert W Yeh[1]





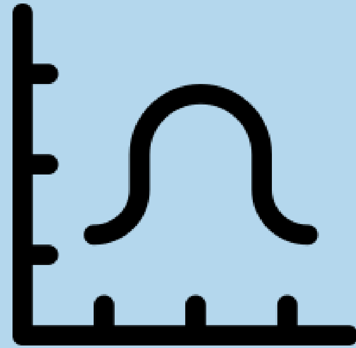




Readmissions from the Emergency Department

Scoping the problem

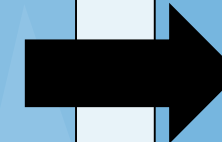
ED *does NOT select* patients for care



ED readmission practices *vary*

Hospitalization decisions are *complex*

Some readmissions are *unavoidable*



How to discharge the *avoidable* readmission?

"If I had one hour to save the world, I would spend *fifty-five minutes* defining the problem and only *five minutes* finding the solution."

- Albert Einstein

“If you can't describe what you are doing as a process, you don't know what you're doing.”

- W. Edwards Deming

“Leaping to the intervention is frequently why quality fails to improve.”

- Keith Kocher

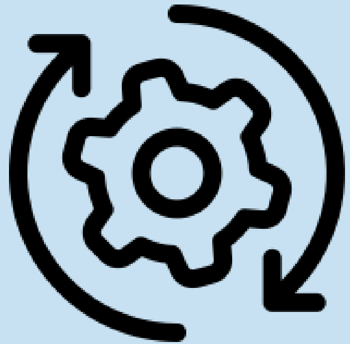
Solutions Are Local

- *Don't skip critical foundational steps:*
  - ✓ Approach humbly with curiosity
  - ✓ Solicit stakeholder input & ownership
  - ✓ Go to the gemba

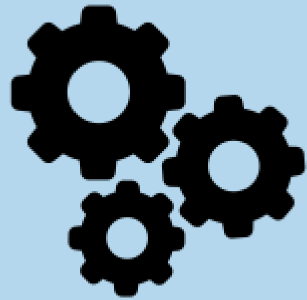
- *Then design with the end in mind:*
  - ✓ Define the problem (what's your scope?)
  - ✓ Define the measures
  - ✓ Invest in the relationships, time, and resources

Readmissions from the ED: Value Proposition

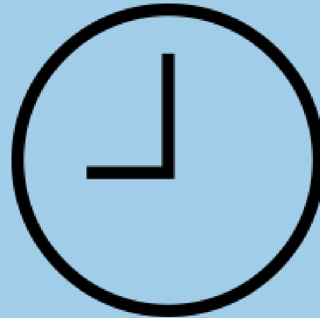
Intervention key considerations



ED discharge = a transition of care!



Do not rely on ED providers



Functions 24/7/365

Address provider needs

Address patient & family needs

Questions/Comments

MVC Upcoming Events

MVC Upcoming Events

WORKGROUPS	REGIONAL EVENTS
CHF: May 13th Chronic Disease Management: May 19th Joint Replacement: May 25th COPD: June 8th Diabetes: June 16th Sepsis: June 14th	Region 3 Coffee, Chat and Collaborate: May 17th Northern Summer Meeting: June 15th
SEMI ANNUAL MEETINGS	**ADDITIONAL**
MVC Fall Semi-Annual Meeting: October 29th	Report Roundtable Discussion: June 21st

MVC Michigan Value Collaborative

Blue Cross Blue Shield Blue Care Network of Michigan

Thank You

If you have any questions or wish to get in touch with the MVC Coordinating Center, please email:

michiganvaluecollaborative@gmail.com