Michigan Value Collaborative

POSTER SESSION
FALL 2023

MICHIGANVALUE.ORG

MEDICAL OBSERVATION COHORT:

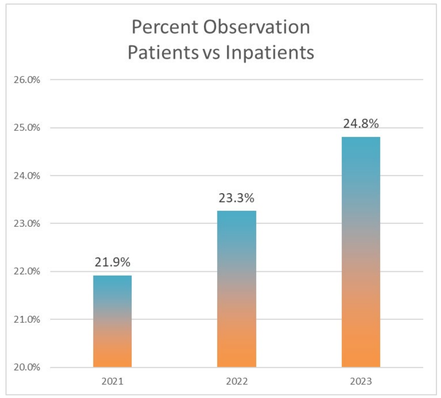
Improving Efficiency in the Acute Care Setting

Executive Summary:

As criteria and payer rules evolve and acute care sees more and more care transition away from inpatient into observation class, it is imperative that hospitals and health systems use acute care resources judiciously in the observation class. By cohorting patients in this class, processes can be standardized to deliver high quality care in the most efficient manner

Problem & Importance

Pressures on the hospital from several directions are pushing teams to look at their work from new perspectives to drive quality, efficiency and sustainability. With staffing challenges, changes to payer rules and admission criteria that push patients into an observation status over an inpatient admission with DRG based reimbursement, hospitals cannot risk inefficiencies in the management of observation patients.



What We Measured

Baseline (Oct 2022 – Feb 2023)

Observation Length of Stay (LOS): 2.45 Days

SMART Target

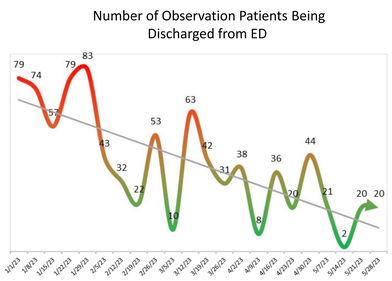
Reduce Observation LOS by 10%

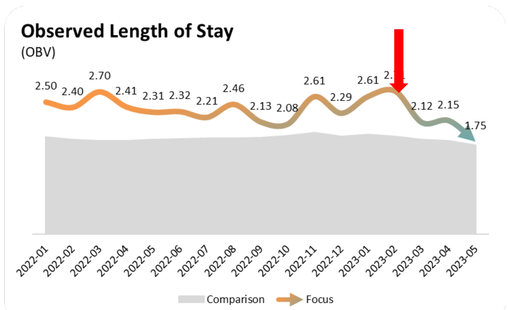
Goal: 2.21 Days

Gap to Close (*Target Minus Baseline*)

Decrease LOS 0.24 Days

Understanding the Current State





Post pandemic, the hospital was experiencing extensive pressure from boarding patients in the emergency department. Due to bed constraints, observation patients were being placed where there was capacity over. As depicted in the upper left, many patients never left the ED during their entire observation encounter. This decentralization of observation patients impacted efficiency and created risk in areas of quality, patient satisfaction, and throughput.

Analysis & Interventions to Improve

After an analysis of demand, a unit of the hospital became dedicated space for placement and management of medical observation patients who were admitted to our general medicine or trauma admitting services. Standardized multidisciplinary rounding and physician tools were deployed to ensure that patients we progressing.

Multidisciplinary Rounds:

Rounds begin at 10 AM, patients will be presented by admitting service in the following order –

1) Trauma
2) Family Medicine
3) FIRM
4) Vituity

Patient presentation at multidisciplinary rounds –

- Name, Age, Sex, Code Status
- OBV LOS in hours
- Presentation/primary diagnosis
- Treatment (inc. ability to DC tele)
- Complications of the stay (if applicable)
- New developments over last 4 hours (labs, prn meds, clinical changes)
- Discharge plan including barriers to discharge

Recommended Patient List Columns:

- In addition to what the team traditionally uses, the patient list should include "Current Time in Obs" and "Patient Class", as well as "Case Manager" and "Tele".

Daily Progress Notes:

- Daily notes should have time stamped updates every 4-6 hours documenting clinical decision making, plan next steps, and justification for continued observation stay. We can provide examples to share with your team if desired.

Scheduled Lab Draws:

- To expedite labs and decrease the risk of delayed am draws/results, scheduled labs will be timed for 2130. This will allow draws to occur in the window of our greatest phlebotomy staffing. Please note that services will need to have a process to address potential overnight critical lab values.

Radiology Orders:

- Studies should be marked "pending discharge" if results are critical to making discharge/flip to IP disposition decisions in the next 24 hours

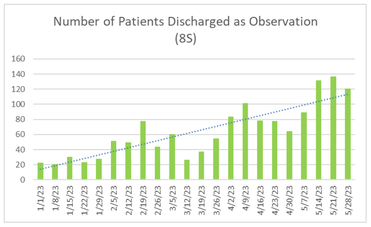
Results & Outcomes Achieved

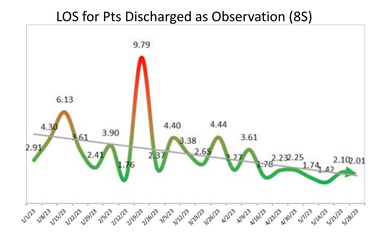
Through this pilot, the number of patients who are being served through this observation center has significantly increased while shortening our overall observation length of stay for both patients who are discharged from this unit and observation length of stay for the hospital overall.

Observation Length of Stay for the medical observation cohort dropped to 1.90 in the first month.

Observation length of stay for EW Sparrow improved from the baseline of 2.45 to 2.00 for Mar-May 2023.

Team met goal within 3 weeks of pilot initiation





Sustain & Spread

Sustain:

- Continue to monitor percentage of available medical observation beds occupied by medical observation patients
- Continue real time feedback of patients presently admitted over 30 hours, pathway compliance, and nursing mobility assessments and interventions (leading measures)

Spread:

- Include all medical observation patient populations not in the initial pilot (neurology/stroke. Cardiology, etc)
- Replicate efficiencies by standing up an additional unit that will focus on management of surgical observation patients

Keys to Success

- Multidisciplinary approach that includes providers, case management , nursing, and therapy services
- Understanding of payer rules and objectives in management of observation class patients
- Collaboration with ambulatory providers to transition patients who need continued services post hospital encounter to ensure timely follow up/continuation of care

Team Members and Contacts

Lisa Powell, Director of Clinical Operations
Lisa.powell@sparrow.org
Dr. Heba Mahmoud, Medical Director, Hospital Medicine (Vituity)
Heba.mahmoud@vituity.com
Amy Brunger, Nursing Manager, Medical Observation
Amy.brunger@sparrow.org

Comorbidity Capture: Malnutrition

Quantifying the Impact of EMR Technology

Executive Summary: Utilization of EPIC SmartLink technology to achieve measurable improvements in malnutrition diagnosis capture

Problem & Importance

Malnutrition affects an estimated 20-50% of hospitalized adults. The presence of malnutrition is associated with increased risk of complications, higher severity of illness, and increased risk of readmission. Documentation of malnutrition ensures that the condition is addressed as part of the care plan and interventions are facilitated.

The Registered Dietitian (RD) is well-positioned to identify, document and intervene when malnutrition is present. Information collected by the RD must be efficiently communicated to the provider team to coordinate care, make formal diagnosis, and ensure an appropriate ICD-10 diagnostic code and diagnosis-related group (DRG) are assigned.

Efficient communication and documentation systems can be difficult to optimize. E.W. Sparrow Hospital (EWSH) was capturing significantly less malnutrition than counterparts, resulting in suboptimal reimbursement and excessive documentation and coding queries.

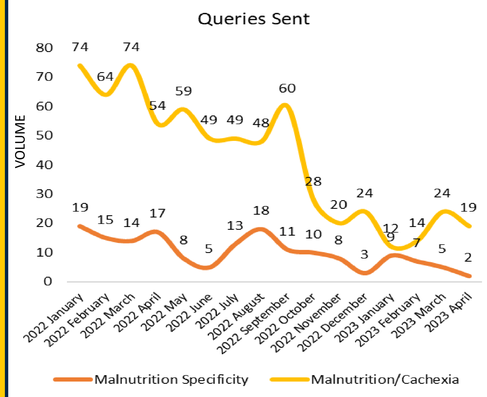
What We Measured

Baseline (Jan-Dec 2022): All DRG Malnutrition Capture was 5.7%

SMART Target: Improve all DRG malnutrition capture by 10% following 6 months of EPIC SmartLink utilization

Gap to Close (*Target Minus Baseline*): Goal is 6.27%

Understanding the Current State

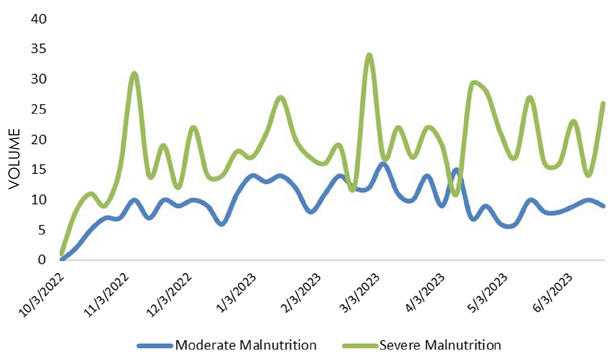


In 2022, an average of 5.7% of patients had a coded malnutrition diagnosis during hospitalization at EWSH. This capture rate was determined to be significantly less than expected prevalence.

Prior to intervention, provider documentation queries were frequently issued to address instances where RD and provider documentation did not align, or the severity of malnutrition was not clearly defined. Malnutrition codes could not be assigned until each query was appropriately addressed.

Analysis & Interventions to Improve

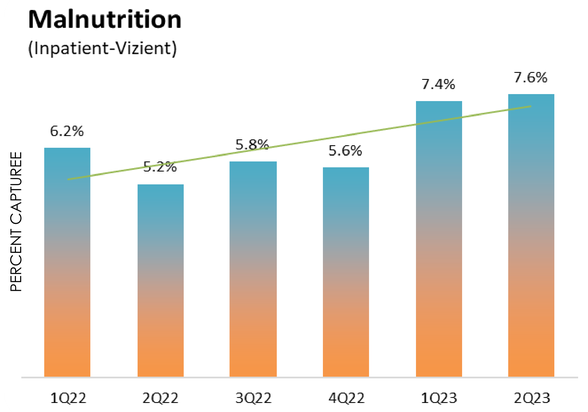
In October 2022, EWSH began utilizing an EPIC SmartLink that identifies when standardized malnutrition language is present within RD notes. When detected, the SmartLink auto-documents the information into the provider's note template. Malnutrition can then be coded as a diagnosis. EWSH began to track volume of auto documentation to determine if utilization would correlate with improvements in the number of queries issued and percentage of malnutrition diagnoses captured.



Results & Outcomes Achieved

At the conclusion of Q2 2023, malnutrition capture improved from a baseline of 5.7% to an average of 7.5%. The initial Q1 2023 capture increase exceeded our goal on an accelerated timeline.

Directly following SmartLink implementation, physician queries for malnutrition/cachexia dropped from an average of 60 queries monthly to an average of 20 queries monthly. Improvement was also noted in queries issued for specificity.



Sustain & Spread

- The SmartLink is live in EPIC and without anticipated expiration
- Malnutrition capture nationwide falls below estimated prevalence. Revision of EWSH's goal for malnutrition capture has potential to be revised as further investment in nutrition screening processes and workflow optimization are prioritized and financial impact is quantified
- The utilization of EPIC SmartLink technology can integrate into targeted areas of patient care when opportunities to improve comorbidity capture are identified

Keys to Success

- **Collaboration** between Clinical Nutrition & Quality Improvement to ensure standardized documentation was conducive to RD/provider workflow and practice standards
- Utilizing **technology** to achieve efficient documentation processes
- Addressing gaps in comorbidity capture aligns with hospital goals to achieve **financial targets** and address **length of stay**

Team Members and Contacts

- Lisa Powell, Director of Clinical Operations: Lisa.Powell@sparrow.org
- Alex Thompson, Clinical Nutrition Manager: Alexandra.Thompson@sparrow.org
- Brande Baxter, Quality Analyst II

Overall Quality of Care
Sparrow Specialty Hospital

Marti Samsel BSN RN
Donivan Wells BSN RN
Dennis Jones BS NHA PTA
Christopher Stimson BS RN CEN TCRN

Executive Summary

Sparrow Specialty Hospital scored in the 78th percentile for Overall Quality of Care in 2017. By focusing on key drivers, Sparrow Specialty Hospital was able to sustain top decile ranking for three consecutive years (2020-2022).

Problem & Importance

Sparrow Specialty Hospital (SSH) is a 30 bed, Long Term Acute Care Hospital (LTACH).

SSH is dedicated to providing quality compassionate care to everyone, every time. Our health system's goal is to move our results to the top quartile or higher in all measurements (people, service, quality, resources, growth).

SSH participates in patient satisfaction surveys through PRC (Professional Research Consultants) with varying results. The selected benchmark group is medical units due to no LTACH comparison group.

What We Measured

Baseline 2017: 78th Percentile for Overall Quality of Care

SMART Target: 90th Percentile for Overall Quality of Care by 2020

Gap to Close: Increase *12 percentile points* by 2020 utilizing key drivers in the patient experience

Understanding the Current State

KEY DRIVER RESULTS
2017 YEAR

Patient Satisfaction (Perception) 2017 Results by the numbers:

Focus Question

"Overall Quality of Care" 61% Excellent (78th percentile)

Key Drivers

"Discharge Process" 42% Excellent (25th percentile)

"Instructions for care at home" 41% Excellent (11th percentile)

OBSTACLES IDENTIFIED

- Discharge phone call connectivity rate was low, and process was unclear
- Key scripting using the phrases "excellent" and "include you in" and "discharge process" needed to occur to help the patient connect the actions being done
- National staffing challenges, increased stress, and increased work-load during high census times
- Low survey return rate

Interdisciplinary Analysis

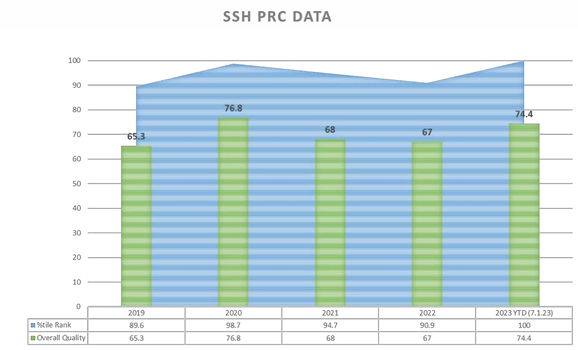
An interdisciplinary team completed a PDCA (Plan-Do-Check-Act) Process to review our current results to identify obstacles and to create an action plan for improvement

1. Utilized two structured process tools to understand the current state (SIPOC & A3)
2. Utilized patient satisfaction survey "key drivers" from PRC to identify areas of focus which provide the greatest impact to improve Overall Quality
3. Utilized staff feedback to identify obstacles and provide recommendations for improvement
4. Identified need for improvement with discharge phone calls which were inconsistent
5. Improved feedback with patient compliments to front line caregivers to improve engagement

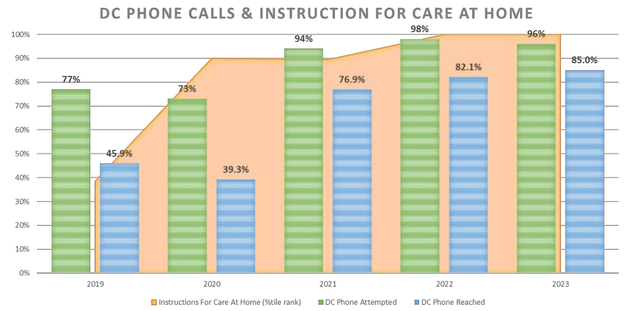
Plan

1. Identify obstacles to completing DC phone calls and create plan for improvement
2. Use key scripting in patient rounds, DC care rounds and DC phone calls
3. Leadership rounding prior to discharge
4. Focus on collecting surveys prior to discharge with key scripting
5. Communicate outcome measures and patient feedback with front line caregivers

Results & Outcomes Achieved



SSH achieved its highest results for Overall Quality of Care with 76.8% Excellent (98.7th percentile) for 2020 and has maintained top decile responses through 2023 YTD



SSH received the *5 Star Excellence Award* for these results for three consecutive years (2020, 2021 & 2022)

Next Steps

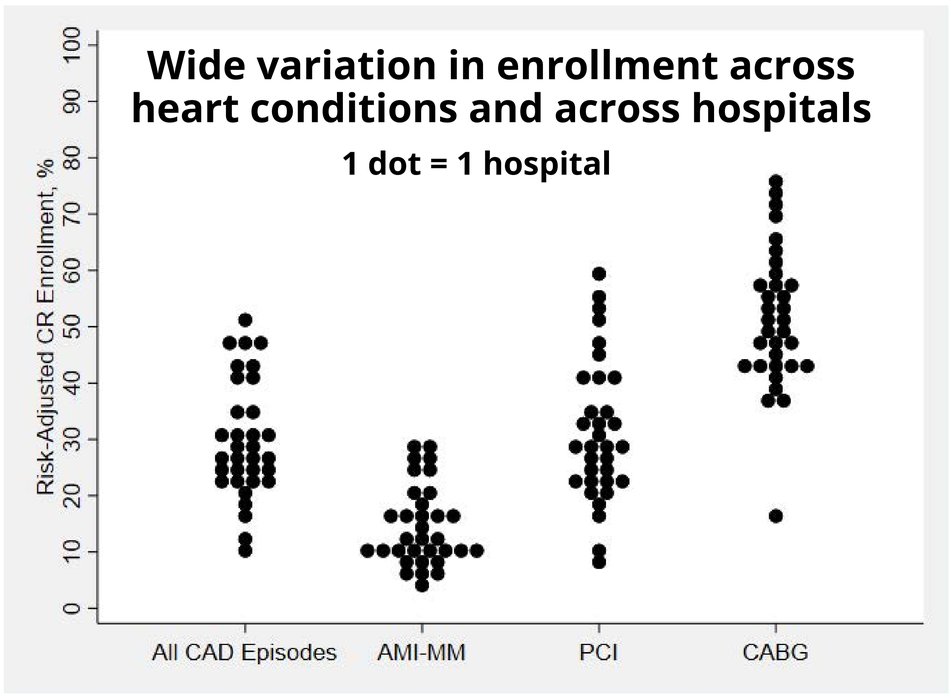
1. Continue our PDCA (Plan-Do-Check-Act) PI process, auditing and coaching to ensure improvements are sustained. Include key stakeholders in the analysis process
2. Continue to assess key drivers to ensure we are focusing on the correct areas
3. Provide positive feedback to caregivers who are doing the process correctly and provide coaching opportunities for those who need improvement
4. If results decline, ensure we are correctly utilizing the tools put in place

The Michigan Cardiac Rehabilitation Network (MiCR): A Statewide Collaboration To Improve Cardiac Rehabilitation Participation

Michael P. Thompson, Ph.D., Co-Director - Michigan Value Collaborative (mthomps@med.umich.edu); Jessica Yaser, MPH; Analyst - Michigan Value Collaborative (jyaser@med.umich.edu); Devraj Sukul, MD, MS; Associate Director - Blue Cross Blue Shield of Michigan Cardiovascular Consortium (dsukul@med.umich.edu); Annemarie Forrest, RN; Program Manager - Blue Cross Blue Shield of Michigan Cardiovascular Consortium MS, MPH (avassalo@med.umich.edu)

Background

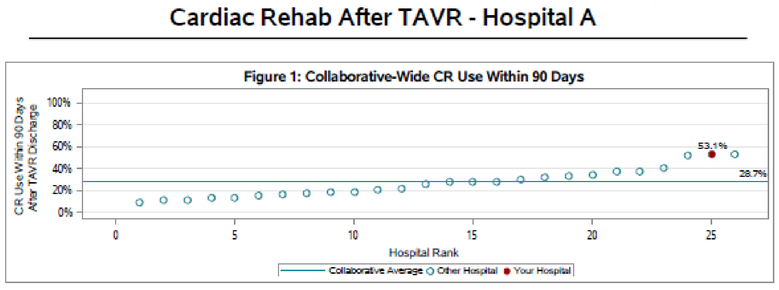
There is currently wide variation in patient enrollment in cardiac rehabilitation (CR) across providers and heart conditions (see figure below). Regional quality improvement collaboratives may provide one solution to improving CR participation through performance benchmarking and provider engagement. The objective of this descriptive study was to evaluate the feasibility of the Michigan Cardiac Rehabilitation Network (MiCR) to improve CR.



Components of MiCR Collaboration

1 Benchmarking Hospital CR Participation

MVC registry data are used to create hospital-specific reports to track and benchmark CR participation.

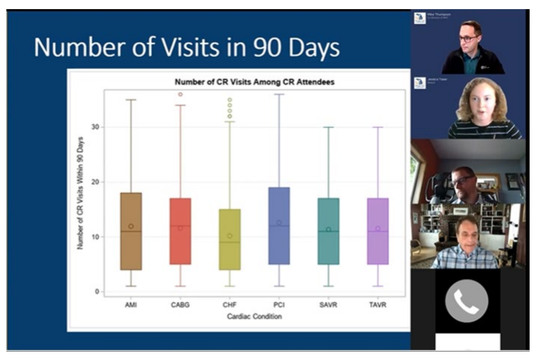


2 Resource Development & Dissemination

MiCR partners developed and disseminated a best practices toolkit to aid quality improvement efforts that improve CR participation.

3 Opportunities for Collaborative Learning

A combination of virtual sessions and in-person meetings are organized to foster a community of trust and collaborative learning.



Insights from Collaborative Learning

MiCR partners completed site visits with Michigan hospitals, which generated insights on barriers and facilitators to improvement.

Communication is Key

Early patient contact, the use of CR liaisons, and automatic referrals all boost CR enrollment.

Build Capacity

Constraints from limited staff, physical space, and other resources prohibit CR facilities from meeting demand.

Leaders Accelerate CR Use

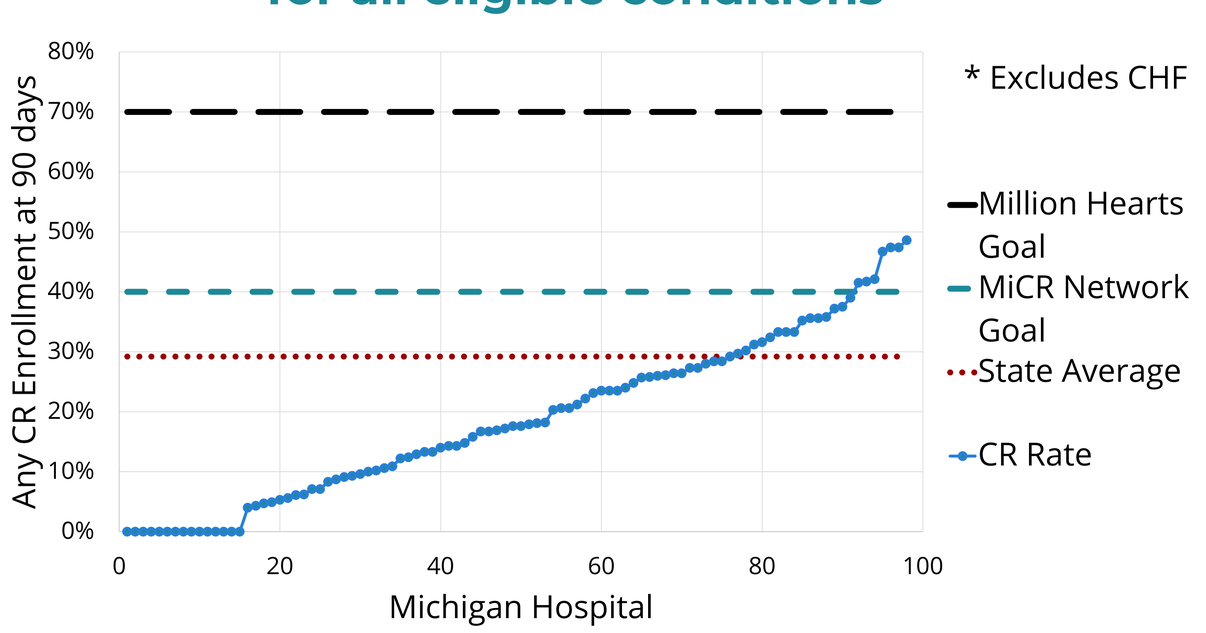
Strong physician endorsement and support from administrative leadership can help a program flourish.

Some Patients Need Help

Patients face additional barriers to CR participation, including costs of attending CR, difficulty scheduling, and transportation challenges.

MiCR Network Statewide Goal

40% CR participation by 2024 for all eligible conditions*



What will success look like?

2,237
Additional Michiganders receiving the benefits of CR

60
Lives saved

$11,000,000
Cost savings

Conclusion

This study demonstrated the feasibility of a statewide collaboration centered around the goal of equitably improving CR enrollment for all eligible patients. Future work will seek to continuously improve and evaluate the impact of this consortium on CR participation in Michigan.

MICHIGAN CARDIAC REHAB NETWORK

MVC Michigan Value Collaborative

BMC2

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

LHSCollaboratory
Putting Data, Knowledge, and Practice into Motion at the University of Michigan