MHA Care Redesign Program Update

Quarterly Newsletter on HCIP and ECIP Implementation

October 2019

HCIP and ECIP DEADLINES

October 31: Protocols Due

December 16: 2020 Q1 Certified Care Partner Lists Due

December 16: Hospital CRP Reports for PP4 Q3 Due

January 3: Next Round of Vetting Lists Due (Anyone New or Ineligible)

Hospital Care Redesign Program Approved for Commercial Expansion

The Maryland Insurance Administration (MIA) recently reviewed the governing documents submitted by Doctors Community Hospital (DCH) on their Hospital Care Improvement Program (HCIP). The MIA concluded that the HCIP program at DCH does not "constitute the business of insurance." This will enable DCH to increase physician engagement by expanding the program to their non-Medicare population. This will permit DHC to engage a broader number physicians by allowing the hospital to pay incentives on both Medicare and commercial cases. The process to expand care redesign programs was authorized by MHA-supported legislation in 2017. Current HCIP participating hospitals should contact Erin Dorrien, to discuss the process for expansion.

Operating Room Resource Utilization Opportunities

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Background

In the spring of 2019, Applied Medical Software distributed a survey to HCIP participating hospitals, asking what Cost Centers or Departments might be areas of opportunity at the participating hospitals. In looking at this, we recognized that the Operating Room might be a good target, one that we had not previously delved into much. The resource reduction opportunities were significant and our participating physician list (i.e. care partners) included a number of surgeons. So we decided to volunteer to share what we were working on with the HCIP User Group. The

Executive Director of Surgical Services, Carol Deal, has been invaluable in this endeavor.

Process

We reviewed the HCIP Reports provided to identify service line opportunities. We recognized in order to use more current data and to dig deeper, we would need to develop reports using internal data. This was both helped and hurt by the hospital's conversion to EPIC but ultimately this change allowed us to develop focused reports in problem areas.

The next step was to meet with surgeons. It was essential that we share the data we collected, and ask what they saw were the issues. More times than not they could quickly verify what we thought was going on and provide feedback as to how we might proceed. These discussions also allowed us to gain useful information on what processes they were doing at other hospitals. Often this presented new ways to view an issue and/or develop actions to address an issue. An important lesson learned from these discussions was that it is crucial to ensure that everyone is using the same definitions. Room turn-around can mean one thing to one surgeon, something else to the nursing staff and an entirely different thing to the anesthesiologist.

Some of the issues we have begun to explore in our discussions include:

- Is room turn-around time different if the room is occupied by one service?
- What metrics and outcomes do we deem most important?
- How can anesthesiology impact efficiency and through-put?
- Are there differences between the practices of a hospital owned practice versus a private practice?
- Do physicians who have a stake in an ambulatory surgery center practice differently than those that don't?

As we move forward, our next goal is to incorporate the anesthesiologists into the process as it is clear they can make a significant impact on the flow of the operating rooms. While supply costs are not included in the HCIP reports, it is an important component to consider and we will be exploring ways to evaluate this. Long-term, we hope to improve through-put, increase opportunities for more surgical volume and, perhaps most importantly, keep our surgeons engaged in the process.

For additional suggested reading from the author, click here.